STATE OF WISCONSIN

DEPARTMENT OF HEALTH AND FAMILY SERVICES

WISCONSIN MEDICAID PROGRAM

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METHODS OF IMPLEMENTATION FOR WISCONSIN MEDICAID NURSING HOME PAYMENT RATES
FOR THE PERIOD JULY 1, 2006 THROUGH JUNE 30, 2007

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SECTION 1.000 INTRODUCTION

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1.110 General Purpose

The purpose of the Wisconsin Medicaid Methods of Implementation for Medicaid Nursing Home Payment Rates is to ensure that nursing homes, including nursing facilities (NF), and intermediate care facilities for the mentally retarded (ICF-MR), are paid appropriately for care provided to Medicaid residents in a cost-efficient fashion.

Wisconsin nursing homes participating in Wisconsin Medicaid are paid by a prospective rate-setting methodology as stipulated in s. 49.45(6m), Wis. Stats. This methodology must meet federal standards and is established in the Methods issued annually by the Wisconsin Department of Health and Family Services, hereafter known as the Department. Within the Department, the Division of Health Care Financing (DHCF) has primary responsibility for establishing nursing home payment rates.

The Department shall develop such administrative policies and procedures as are necessary and proper to implement the provisions outlined in the Methods. This information shall be communicated to the nursing home industry as necessary, such as through program memoranda, provider handbooks, and Medicaid Updates. Such policies and procedures are generally intended to apply to usual and customary situations and are not necessarily applicable to special situations and circumstances. Any questions regarding specific circumstances should be referred to the Department.

It should be noted that the Department develops standardized calculation worksheets for the computation of payment rates under the Methods. These worksheets are an administrative tool and are generally intended to apply only to usual and customary situations.

1.115 Further Information

For further information, contact:

Nursing Home Section
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

Individual nursing homes should contact their district Medicaid auditor for specific questions on their payment rates.

1.120 Basis of the Nursing Home Payment Rates

Allowable payment levels were determined by the Department through examination of costs actually incurred by a sample of nursing homes in Wisconsin. Appropriate adjustments for actual and anticipated inflation levels were taken into account in projecting costs. One provision in these Methods helps assure that necessary and appropriate care continues to be provided by facilities which may not be economically and efficiently operated and which face unique fiscal circumstances. The Nursing Home Appeals Board helps ensure cost-effective operations and yet recognize exceptional circumstances, if warranted.

The Nursing Home Appeals Board is available for redress in the event a facility has extraordinary fiscal circumstances, as defined by statute 49.45(6m)(e) shown below.

49.45(6m)(e) The department shall establish an appeals mechanism within the department to review petitions from facilities providing skilled, intermediate, limited, personal or residential care or providing care for the mentally retarded for modifications to any payment under this subsection. The department may, upon the presentation of facts, modify a payment if demonstrated substantial inequities exist for the period appealed. Upon review of the department's decision the secretary may grant the modifications, which may exceed maximum payment levels allowed under this subsection but may not exceed federal maximum reimbursement levels. The department shall develop specific criteria and standards for granting payment modifications, and shall take into account the following, without limitation because of enumeration, in reviewing petitions for modification:

1. The efficiency and effectiveness of the facility if compared with facilities providing similar services and if valid cost variations are considered.

2. The effect of rate modifications upon compliance with federal regulations authorized under 42 USC1396 to 1396p.

3. The need for ad+ditional revenue to correct licensure and certification deficiencies.

4. The relationship between total revenue and total costs for all patients.

5. The existence and effectiveness of specialized programs for the chronically mentally ill or developmentally disabled.

6. Exceptional patient needs.

7. Demonstrated experience in providing high quality patient care.

1.130 Authority and Interpretation of 2006-2007 Methods

These Methods will determine payment for services provided during the twelve-month time period of July 1, 2006, through June 30, 2007, unless otherwise modified by legislative action, or federal or court direction. A new rate period begins with services rendered on or after July 1, 2006.

1.131 Severability

The provisions of the Methods of Implementation for the Medicaid Nursing Home Payment Rates are to be considered separate and severable.

1.132 Effective Period of Payment Rates

Rates shall be implemented on or after July 1, 2006, unless otherwise specified. Rates issued after July 1, 2006, shall be approved retroactively to July 1, 2006. However, rates may be approved effective on a later date under the provisions of Section 4.000 Rate Adjustments and Recalculations of these Methods.

1.133 Authority of 2007-2008 Methods

Applicable nursing home payment rates for services rendered on or after July 1, 2007, will be governed by the provisions of a separate, new 2007-2008 Methods, even if the 2007-2008 Methods are issued subsequent to July 1, 2007. Reimbursement rates established under one Methods will apply only to that reimbursement period.

1.134 Recoupment of Overpayment

Upon a rate decrease for any purpose, any excess payments for previously provided services shall be recovered from the provider. The amount to be recovered shall be determined by the Department or its fiscal agent. The amount shall be recovered within a recovery period not to exceed 60 days. Requests for a recovery period should be submitted to the fiscal agent.

As a standard procedure, the Department will recover the recovery amount by deducting, from each current remittance to the provider, a fixed percentage of each remittance. The Department shall establish the fixed percentage. If the total amount is not fully recovered within the first 30 days of the recovery period, then the Department may establish larger repayment installments in order to assure the total amount is fully recovered by the end of the 60 day recovery period.

If enough Accounts Receivable shall not be generated by the fiscal intermediary to recover 100% of the funds within 60 days, a lump sum payment shall be made to the Department for the difference. In addition, if the Department's fiscal agent cannot determine the amount of the recovery, the amount will be determined by the Department. In these situations, the recovery amount shall also be recovered within 60 days and may either be deducted from current remittances to the provider or repaid by the provider to the Department's fiscal agent.

1.140 Litigation

The State has been or may be involved in litigation concerning the validity or application of provisions contained in this Methods or provisions of previous Methods. Medicaid payments resulting from entry of any court order may be rescinded or recouped, in whole or in part, by the Department if that court order is subsequently vacated, reversed or otherwise modified, or if the Department ultimately prevails in litigation. When recoupment occurs, recoupment will be made from all facilities affected by the issuance of the

court order, whether or not such facilities were parties to the litigation. If any provision of this Methods is properly and legally modified or overturned, the remaining provisions of this Methods are still valid.

1.160 Medicaid Participation Requirements

All nursing homes participating in the Medicaid program must meet established certification requirements, adopt a uniform accounting system, file a cost report, and disclose the financial and other information necessary for verification of the services provided and costs incurred. The Department will specify the time periods and forms used for those purposes.

1.170 Cost and Survey Reporting Requirements

1.171 Cost Reporting

All certified nursing home providers must annually submit a "Medicaid Nursing Home Cost Report" for the period of the home's fiscal year. Under special circumstances, the Department may require or allow a provider to submit a cost report for an alternative period of time. A standardized cost reporting form and related instruction booklet, which include detailed policies and instructions for cost reporting, are provided by the Department. This cost report and the related cost report instruction booklet along with policies adopted by the Department, are an integral and important part in determining payment rates. Additionally, the Department may require providers to submit supplemental information beyond that which is required in the cost report form. Supplemental information concerning related entities shall be made available on request. The intent of cost reporting is to identify the costs incurred by the nursing home provider to be used in the application of the Medicaid payment policies and methodology.

1.171(b) All Certified Nursing Home Providers Must Submit

An annual survey of nursing homes on report forms and/or in an electronic format that meets the Department's specifications. The Annual Survey of Nursing Homes report form options and instructions are provided by the Department. Reports must be based on the calendar year or the portion of the calendar year during which the nursing home was in operation.

1.172 Signature

If the cost report or annual survey is prepared by a party other than the nursing home owner or a nursing home employee, it must be signed by both the preparer and the owner/employee.

1.173 Timely Submission

The completed cost report is due to the Department within three months after the end of the cost reporting period unless the Department allows additional time. The due date of supplemental information, including responses to DHCF questions, will depend on the complexity and need for the information being required. The due dates for cost reports for the Nursing Home Appeals Board shall be established by the Board and may be less than three months. The Department shall establish and implement policies to withhold payment to a provider, or decrease or freeze payment rates, if a provider does not submit cost reports and required supplemental information and responses to DHCF questions by the due dates.

The completed Annual Survey of Nursing Homes is due to the Department by February 1 of each year, unless the Department allows a maximum 28 day extension. The Department shall establish and implement policies to withhold payment to a provider, or decrease or freeze payment rates, if a provider does not submit annual survey forms and respond to the Department by the due date.

Failure to pay the Licensed Bed Assessment in a timely fashion will also cause the Department to withhold payment to a provider.

Facilities that do not meet the requirements of this section will have payment rates reduced according to the following schedule:

1. 25% for cost reports, supplemental information, licensed bed assessments and/or annual surveys between 1 and 30 days overdue.

2. 50% for cost reports, supplemental information, licensed bed assessments and/or annual surveys between 31 and 60 days overdue.

3. 75% for cost reports, supplemental information, licensed bed assessments and/or annual surveys between 61 and 90 days overdue.

4. 100% for cost reports, supplemental information, licensed bed assessments and/or annual surveys more than 90 days overdue.

The number of days overdue shall be measured from the original due date, without extension, of the cost report, supplemental information, licensed bed assessment and/or nursing home survey.

The rates will be retroactively restored once the cost report, supplemental information, licensed bed assessment and/or nursing home survey is submitted to the Department.

1.174 Records Retention

Providers must retain all financial records, statistical records and worksheets to support their cost report and supplemental information for a period of five years. (Reference: HFS 105.02, Wis. Adm. Code). Records and worksheets must be accurate and in sufficient detail to substantiate the reported financial and statistical data. These records must be made available to the Department or the United States Department of Health and Human Services within a reasonable time from the date of request and at a location within Wisconsin unless alternative arrangements can be made with the Department. Failure to adequately support reported amounts may result in retroactive reductions of payment rates and recoveries of monies paid for services.

1.175 Change of Ownership

Upon change of ownership of a nursing home operation, the prior owner is required to submit a cost report for the fiscal period prior to the ownership change unless the Department determines the cost report is not needed. The prior owner's failure to submit such a cost report may limit the new provider's payment rates. IT IS IMPORTANT THAT THE NEW OWNER ASSURE THAT THE PRIOR OWNER SUBMITS THE COST REPORT. Also see Sections 4.200 through 4.230.

1.176 Combined Cost Report for Multiple Providers

A separate cost report is to be submitted by each separately certified nursing home provider. Nevertheless, the Department may allow or require two or more separately certified providers to submit a single combined cost report in the following circumstances:

1. Multiple Certified Nursing Homes. A combined cost report may be allowed or required for two or more separately certified nursing homes which are located on the same or contiguous property and which are fully owned by the same corporation, governmental unit or group of individuals.

2. Small Nursing Homes. A combined cost report may be allowed or required for two or more separately certified nursing homes when each has a capacity of less than 25 licensed beds and when all are fully owned by the same corporation, governmental unit or group of individuals.

3. Distinct Part ICF-MRs. A provider operating in conjunction with a distinct part ICF-MR provider, as defined in Section 1.311, shall be required to submit a combined cost report for both providers.

4. Distinct Part IMDs. A provider operating in conjunction with a distinct part institution for mental disease (distinct part IMD) provider, as defined in Section 1.312, shall submit a combined cost report. However, the Department may require separate cost reports depending on individual circumstances.

The Department shall not allow a combined cost report for a facility if the Department estimates that payment rates which are determined from such a report are likely to result in payments which are substantially in excess of the amount which would be paid if separate cost reports were submitted. The Department shall not allow a combined cost report if a facility's rates cannot be readily or appropriately calculated based on such a report.

1.200 ALLOWABLE EXPENSES

1.210 Patient Care Related Expenses

Only expenses incurred by the nursing home related to nursing home patient care shall be allowable for payment. Expenses related to patient care include all necessary and proper expenses which are appropriate in developing and maintaining the operation of nursing

home facilities and services. Necessary and proper expenses are usually expenses incurred by a reasonably prudent buyer which are common and accepted occurrences in the operation of a nursing home.

1.215 Sanctions

Allowable expenses do not include forfeitures, civil money penalties or fines assessed under Wisconsin Statutes, Administrative Rules, Federal Regulations or local ordinances.

1.220 Bad Debts

Bad debts and charity and courtesy allowances applicable to any patient shall not be allowable expenses.

1.230 Prudent Buyer

The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, but also seeks to economize by minimizing cost. Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicaid providers of services will also seek them.

The Department may employ various means for detecting and investigating situations in which costs seem excessive. These techniques may include, but are not limited to, comparing the prices paid by providers to the prices paid for similar items or services by comparable purchasers; spot-checking; and querying providers about direct and indirect discounts. In those cases where the Department notes that a provider pays substantially more than the going price for a supply or service in the absence of clear justification for the premium, the Department will exclude excess costs in determining allowable costs for payment rates.

1.240 Approvals under the State's Resource Allocation Program: Long-Term Care

Unless otherwise specified in this Methods, payment shall not be provided for expenses related to capital projects or changes in service which were not approved or for which notice was not given (if required) under Section 1122 of the Social Security Act or Chapter 150, Wis. Stats.

The Department shall retroactively reverse or negate the effect of rate adjustments due to a Resource Allocation Program project if the facilities did not complete the projects.

1.241 Workers Compensation

By Statute, nursing homes are required to provide Workers Compensation (WC) insurance for their employees. The Wisconsin Compensation Rating Bureau (WCRB) has the authority to establish rates for WC insurance. The allowed WC cost will be the lesser of the calculated amounts obtained from the WCRB WC policy for a given nursing home or allowable cost of a self insurance plan.

WC expenses may need to be accrued on an estimated basis since subsequent audit may result in an adjustment to the Experience Modification Factor (EMF) resulting in additional costs or refunds for the cost reporting period. Allowed WC expense will be the amount accrued and paid within 75 days of the end of the cost report period. Any changes to previously estimated Workers Compensation amounts that result in additional costs or refunds shall be reported as an addition or reduction of WC expense in the cost reporting period that they
become known.

1.245 Legal and Other Professional Fees

Under the following circumstances, legal and other professional fees incurred by a provider are not related to patient care and are thus not allowable expenses:

1. The provider (or an organization of which a provider is a member) incurs the fees for the prosecution or defense or potential prosecution or defense of any administrative appeal or judicial suit which results from any reimbursement action taken by a state or federal agency administering Title XVIII or Medicaid programs.

2. The provider (or an organization of which a provider is a member) incurs the fees in an administrative appeal or judicial suit which results from any action by the state agency that administers licensing and certification requirements, unless the administrative law judge in the administrative appeal awards fees in a motion brought under Section 1.2455.

3. The provider incurs fees defending an owner or an employee in any personal matter or in any criminal investigation or prosecution.

4. The provider incurs the fees in any other remedial process pursued prior to the filing of an appeal under CHs. 50 or 227, Wis. Stats., or a judicial suit.

5. Other fees not related to patient care.

1.2455 Award of Fees

The treatment of legal fees and other professional fees incurred in a provider's administrative appeal of any action by a state agency that administers licensing and certification requirements shall be as follows:

1. Upon resolution of any such appeal, the provider or the state agency may submit a motion for award of fees to the administrative law judge. The judge shall award fees if the judge determines that the moving party is the "prevailing party," unless the judge determines that the other party had a reasonable basis in law and fact for taking its position or that special circumstances exist that would make an award unjust. The judge shall determine the prevailing party and the amount of the award pursuant to ss. 227.485(4) and 814.245(5), Stats., except that the amount of the award shall not include any fees associated with preparing, submitting or litigating the motion for fees. The judge's decision is not subject to judicial review.

2. If the fees are awarded to the provider under this section, the amount awarded will be treated as an allowable expense in the cost report year or years in which the fees were incurred, to the extent the amount does not exceed the Administrative and General cost center maximum limitation under Section 3.210 of the Methods. If the fees are awarded to the Department in its role as state licensing or certification agency, the amount awarded will be deducted from the provider's otherwise allowable costs in the Administrative and General cost center for the cost report year or years in which the fees were incurred.

3. Section 227.485, Stats., is intended to allow an administrative law judge to award costs associated with a hearing to the prevailing party in the proceeding, upon motion of that party, but it only allows such awards for individuals, small non-profit corporations, or small businesses. Providers who are individuals, small non-profit corporations or small businesses, and who pursue costs under s. 227.485, Stats., shall not be entitled to, in addition, pursue costs under the provisions of this state plan.

1.246 Accruals of Paid Time Off

The Department will not recognize the accruals of expenses for paid time off. It will recognize only the cost of paid time off (i.e. vacations, sick leave, etc.) which has been paid during the cost reporting period.

1.247 On-Premise Time Off

On-premise paid time off (i.e., break time, paid meal time, etc.) should be reported as productive time and wages.

1.248 Self-Insurance Costs

The allowable expense for self-insurance plans is the actual claims paid during the cost reporting period. At the facility's option, accrual of pending claims may be made to the extent that such claims are paid within 75 days of the close of the cost reporting period. Such accrued claims may not be expensed in the following year's cost report. If a facility's self-insurance fund is managed by an independent (non-related) trustee, the fee paid to the trustee may be included in allowable self-insurance costs. If actuarial determinations are performed by an independent (non-related, non-employee) actuary, the fee paid to the actuary may be included in allowable self-insurance costs. Allowable self-insurance costs may also include the premium costs of re-insurance ("stop-loss") policies purchased from an unrelated company and any costs to administer the self insurance plan. Allowable costs shall then be reduced for investment income. In order for investment income to remain in the self insurance allowable cost determination, it must be separately identified and accounted for as related to the self insurance plan. If not separately identified, investment income will be treated according to Section 1.270 and/or Section 3.526. Any proceeds from these policies will be offset against the claims paid during the cost reporting period of receipt.

For purposes of implementing this section and payment plan, the terms self-insurance and self-funded are synonymous. Self-insurance is a means where a provider, either directly or indirectly or through a separate entity, trust or fund, undertakes the ultimate risk by assuming the actual liability for insurance costs as defined in this section. The creation of a separate entity, trust or fund for insurance purposes does not eliminate the provider's ultimate insurance risk or liability. Payment of insurance premiums to an

insurance company, in the business of offering insurance to the general public, where such premiums are the final liability of the provider regardless of the actual cost incurred by the insurance company does not constitute self-insurance.

1.249 Provider Assessments or Provider Specific Taxes

Reimbursable expenses under these Methods will not include any cost attributable to taxes or assessments on licensed beds imposed by this State solely with respect to nursing homes or ICF-MRs.

1.250 Costs from Related Parties and Related Organizations

1.251 Allowable Related Party Costs

A nursing home may incur expenses for services, facilities and supplies furnished by organizations related to the nursing home by common ownership or control. In lieu of such expenses incurred by the nursing home, allowable expenses for payment may include the expenses incurred by the related organization for the furnished items. Allowable expenses must not exceed the lesser of:

1. The expense incurred by the related organization for the services, facilities or supplies which the related party furnished to the nursing home, or

2. The price of comparable services, facilities or supplies that could be purchased elsewhere.

The purpose of this principle is to avoid the payment of a profit factor to the nursing home through the related organization, and also to avoid payment of artificially inflated expenses which may be generated from less than "arm's length" bargaining.

1.252 Definitions for Related Parties

A "related party" or "related organization" is an individual or organization related to a nursing home by either common ownership or control.

"Related to the nursing home" means that the nursing home, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities or supplies.

"Common ownership" exists when an individual or individuals possess significant ownership or equity in the nursing home and in the institution or organization serving the nursing home.

"Control" exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

"Immediate family relationships" include husband/wife, natural parent, child, sibling, adoptive child and adoptive parent, step-parent, step-child, step-sibling, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent and grandchild.

1.253 Determination of Relatedness

In determining whether a nursing home is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create a rebuttable presumption of relatedness.

1. "Related by Common Ownership." A determination as to whether an individual(s) or organization possesses significant ownership or equity in the nursing home organization and the supplying organization, so as to consider the organizations related by common ownership, should be made on the basis of the facts and circumstances in each case. This principle applies whether the nursing home or the supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (for example, a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).

2. "Related by Control." The term "control" includes any kind of control which is exercisable, regardless of legal enforceability. It is the reality of the control which is decisive, not its form or mode of its exercise. The facts and circumstances in each case must be examined to ascertain whether legal or effective control does exist. Since a determination reached in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same.

3. "Exception." An exception is provided to the general rule applicable to related organizations. The exception is intended to cover situations where large quantities of goods and services are furnished to the general public and only incidentally are furnished to a nursing home by a related organization. The exception applies if the provider demonstrates to the satisfaction of the Department that the following criteria are met:

   a. The supplying organization is a bona fide separate organization.

   b. A substantial part of the supplying organization's business activity as engaged with the nursing home is transacted with other organizations not related to the nursing home and the supplier by common ownership or control AND there is an open, competitive market for the type of services, supplies or facilities furnished by the organization.

   c. The services, supplies or facilities are those which commonly are obtained by nursing homes from other organizations and are not a basic element of patient care ordinarily furnished directly to patients in nursing home operations.

   d. The charge to the nursing home is in line with the charge for such services, supplies or facilities in the open, competitive market, and no more than the charge made by the organization, under comparable circumstances, to other customers for such services, supplies or facilities.

   If all the above conditions are met, the charge by the related supplier to the nursing home for such services, supplies or facilities shall be an allowed expense for payment.

1.254 Documentation

The nursing home must make available to the Department adequate documentation to support the costs incurred by the related organization, including access to the related organization's books and records concerning supplies and services furnished to the nursing home. Such documentation must include an identification of the organization's total costs, and the basis of allocation of direct and indirect costs to the nursing home and to other entities served.

1.255 Medicare Influence

Generally, the Department will refer to the Medicare Program's guidelines and interpretations when examining payment issues arising out of costs to related organizations.

1.256 Related Party Compensation

Any form of compensation to owners or related parties which is included in the payment rate must be reasonable and necessary. "Reasonable" means that the compensation should not exceed what would be paid by other nursing homes or the home in question for similar services. "Necessary" means that the services are required and commonly performed in other nursing homes and that, if the services were not performed by the owner or related individual, another person would have to be employed or contracted to perform them. Workers, who are members of the religious order (or society) which owns the nursing home, are to be treated as related parties under this section.

1.260 Employee Compensation

Any form of compensation which is included in the payment rate must be reasonable and necessary. "Reasonable" means that the compensation should not exceed what would be paid by other nursing homes or the home in question for similar services. "Necessary" means that the services are required and commonly performed in other nursing homes.

1.265 Out-of-State Travel

Out-of-state travel and related travel expenses shall not be allowed, except for travel expenses to and from the nursing home's home office. This provision shall not apply to travel within 100 miles of the Wisconsin border or to home office personnel with one or more nursing homes located outside the State of Wisconsin. Travel expenses shall include but not be limited to meals, lodging, transportation, and all training, seminar and convention fees and expenses associated with the out-of-state trip.

1.266 Definition of Investment Income

Investment income consists of the aggregate net amount from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss is not allowable.

1.270 Interest Expense on Working Capital Debt

Working capital loans are debts entered into by a provider to finance current operations until current cash flow allows payment of the debt. Such debts may carryover from a recent fiscal year to the current fiscal year. Only interest expense on operating working capital loans which are related to patient care shall be allowed to be included in the calculation of the administration and general allowance. The Department shall determine allowable expense and shall include the following adjustments.

1. Revenues from any invested funds shall be offset against working capital interest expense; such revenues remaining after the offset may be offset under Department policy in determining the property allowance per Section 3.500.

    a. Investment income earned by any home office, other corporate entity or organization, foundation or related party that has a purpose of furthering the goals and objectives of the nursing home or its related organizations, shall be offset against the nursing home's allowable interest expense. Long term interest expense and working capital interest expense shall be offset by investment income from all sources (including home office, other corporate entities or organizations, foundations and related parties). Offsets from these entities shall be applied after offsets to interest expense at the home office, other corporate entities or organizations, foundations and related parties are made. Offsets to the nursing home shall be allocated based on the home office or foundation acceptable allocation basis. The investment income offset shall first be applied to working capital interest expense and then to long term interest expense.

    b. Investment income generated to meet specific financial reserve requirements of the Office of Commissioner of Insurance or other regulatory agencies will be exempt from the income offset requirement.

2. Interest expense on borrowed funds which are not used for operating the nursing home shall not be allowable.

3. Interest on debts to acquire plant assets, which is not reimbursed under the property allowance in Section 3.500, shall not be allowed as interest in the administrative component.

1.281 Therapy and Beauty and Barber Shop Spaces

Dietary and environmental services, fuel and utility, property tax, and property expenses which are indirectly allocated to therapy services and beauty and barber services, on the basis of the building area which those services use, shall be generally allowed in the calculation of the payment rate. If gross therapy revenues (physical, occupational, and speech) are less than $100,000 for the applicable cost reporting period, then space allocations will not be made. If gross therapy revenues (physical therapy, occupational therapy, and speech therapy) generated in nursing home therapy space attributable to non-nursing home residents equal 2% or more of total gross therapy revenues and/or if the nursing facility (or a related party as defined in Section 1.252) bills Medicare Part B for therapy generated in the nursing facility therapy space and the Medicare Part B revenues equal 10% or more of the total therapy revenues, then space allocations shall be made on a square footage basis. If the nursing home is subject to an allocation under the Medicare Part B criterion, then the non-nursing home resident allocation will be made if there are any non-nursing home resident therapy revenues. These qualifying criteria are based on the facility's cost reporting period for the payment rates.

1.282 Transportation

Revenues from transportation services shall be offset against transportation or administrative cost center expenses. In lieu of a revenue offset, expenses appropriately allocated by the nursing home to the revenue-generating transportation services may be offset against the cost center expenses.

1.290 Institutions for Mental Disease and Mentally Ill Nursing Home Residents

Sections 1.291 through 1.294 describe limitations on payments to institutions for mental disease and nursing homes for the care of mentally ill residents, as required by 1987 Act 399.

1.291 Limitation on Payment

Operating, capital and ancillary costs attributable to the care of 21 through 64 year old residents of an institution for mental disease are not allowable costs, except that costs for 21 year old residents are allowable if the resident resided in the institution for mental disease immediately prior to turning 21.

1.292 Limitation on IMD Patient Days

This section applies to IMDs and facilities declared to be at risk of being IMDs which agree to receive a permanent limitation on payments, pursuant to s. 46.266(1)(am), Wis. Stats. For these facilities, costs attributable to Medicaid patient days in excess of the patient day cap are not allowable costs. The patient day cap is determined as follows:

Patient day cap = 365*[A + (B-C)], where

A = The number of Medicaid eligible residents of the facility on the date that it is declared an IMD or the date that it is declared at risk of being an IMD.

B = The total licensed beds in the facility on the date that the facility agrees to receive the permanent limitation on payments.

C = The total residents of the facility on the date that it is declared an IMD or the date that it is declared at risk of being an IMD.

The patient day cap may be increased by 365 patient days for each resident who was not eligible for Medicaid on the date the facility was declared an IMD or at risk of being an IMD, but who becomes eligible at a later date.

1.294 Cap on Mentally Ill Nursing Home Residents

Pursuant to s.49.45(6j), Wis. Stats., the number of mentally ill Medicaid recipients in a nursing home determined by the Department to be at risk of being an IMD may not exceed the average population of mentally ill Medicaid recipients age 21 through 64 (excluding persons under 22 who were receiving Medicaid services in the facility prior to July 1, 1988, and continuously thereafter) in the nursing home during the period from January 1, 1987, through June 30, 1988. Costs attributable to mentally ill residents of the facility in excess of the average population are not allowable costs.

1.296 Hospice

Hospice days will be classified to levels of care per Section 1.315. If an NF contracts with a hospice to provide care for a terminally ill resident, costs attributable to care for that resident are not allowable costs.

1.300 GENERAL DEFINITIONS

1.301 Active Treatment

Active treatment for developmentally disabled and mentally ill nursing home residents means an ongoing, organized effort to help each resident attain his or her developmental capacity through the resident's regular participation, in accordance with an individualized plan, in a program of activities designed to enable the resident to attain the optimal physical, intellectual, social and vocational levels of functioning of which he or she is capable.

1.302 Base Cost Reporting Period

Payment rates shall be based upon information from cost reports for the provider's fiscal year ending in the calendar year prior to effective date of the payment rates per Section 1.132, except that the property tax allowance shall be based on the cost reporting periods described under Section 3.400. Payment rates may be based on alternative cost reporting periods acceptable to the Department, whenever allowed under the provisions of Section 4.000 of this Methods.

Expenses included in a reporting period are to be on the accrual basis of accounting, except where otherwise noted. For reimbursement purposes, the accrued expense must be paid within 180 days following the end of the reporting period. An expense disallowed under this section in any cost report period may not be claimed on a subsequent cost report. Specific exceptions to the 180 day rule may be granted by the Department for documented contractual arrangements such as receivership, property tax installment payments, and pension contributions; or expenses relating to audit of another provider group if the audit settlement indicates acceptance of these costs in writing. Note Section 1.248 for pending claims for self-insurance costs.

For 2006-2007 rates, the facilities' 2005 cost reports will be used to calculate payment rates. Exceptions to this may be for facilities in a start-up or phase-down period per Sections 4.300, 4.400, 4.500 and 4.600 as mentioned in Section 1.302.

1.303 Common Period

The common period to which expenses will be inflated or deflated is the twelve-month period preceding the payment rate year described in Section 1.314. For 2006-2007 payment rates, the common period covers the twelve months of July 2005 through June 2006.

1.304 Definition of Significant Changes in Licensed Bed Capacity

Unless otherwise stated in this Methods, a significant increase or decrease in licensed bed capacity is defined as the lesser of: (1) a change that is greater than or equal to 25.0% of the previously unrestricted use licensed beds or (2) 50 beds or (3) a change in licensure to 50 or fewer beds.

1.305 New Facilities

A new facility is defined as a nursing home newly beginning operation and not previously licensed as a nursing home. A change in ownership does not constitute a new facility. An existing operation, which becomes certified for the Medicaid Program, shall not be considered a new facility.

1.306 Replacement Beds and Facilities

A replacement is defined as the licensure and certification by a Medicaid provider of beds to take the place of beds closed or de-licensed by the same or a related provider. Total replacement means all beds under a provider's certification were replaced. The resulting licensed bed capacity of the provider may be considered a significant increase or decrease in licensed beds if the criteria of Section 1.304 are met.

1.308 Fringe Benefits

The term "fringe benefits" refers to general fringe benefits for staff as defined in detail by the Department in the Medicaid nursing home cost report form. Significant, unique benefits, as defined in the cost report form, are to be included as a salary or wage expense under this Methods and not as a fringe benefit expense. For facilities with special salary and wage payments to employees, such as bonuses, the Department shall classify such payments as salaries instead of fringe benefits. The cost of employee meals as a fringe benefit will be the cost per meal in Section 5.450 times the allowable employee meals, less the employee meal revenue. The net cost for employee meals shall not be less than zero.

1.309 Average Licensed Beds

The term "average licensed beds" means the average of the number of licensed beds of the facility on the last day of each month of the period for which the average is being determined. An average for a one-month period shall be the average of the daily number of licensed beds.

1.310 Significant Licensed Bed Days

A significant number of licensed bed days is the lesser of 4500 licensed bed days or 25.0% of the annualized bed days of the provider.

1.311 Distinct Part ICF-MR

A distinct part ICF-MR is a specific segment of a licensed NF facility which has been certified by the Department as a distinct part intermediate care facility for the mentally retarded.

1.312 Institution for Mental Disease (IMD)

An institution for mental disease (IMD) is an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services as determined by the Department or the federal Center for Medicare/Medicaid Services. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental disease.

1.313 Restricted Use Beds

1. Restricted use beds are beds that exceed a nursing home's normal maximum bed capacity or are not in use due to remodeling. If a facility is remodeling a portion of the nursing home, and the beds will not be available until after the remodeling is complete, the beds are shown as restricted use beds. Beds may also be restricted use beds if they are transferred to a nursing home because of one of the following three circumstances: 1) bankruptcy, 2) a physical plant with less than 50 beds that needs replacement, or 3) a physical plant with life safety code problems. This applies if space is currently not available for these beds.

1.314 Payment Rate Year

The payment rate year is the twelve month period from July 1, 2006 through June 30, 2007.

1.315 Patient Day

A patient day is one in which a patient, regardless of pay source, resides in a nursing facility for any part of a calendar day. This includes the day of admission but not the day of discharge. If the day of admission and discharge are the same it will be considered one patient day. Patient days will include all of the following types of days.

Bed hold days reimbursed by the fiscal intermediary or patient are considered a patient day (Medicaid bed hold days must meet the billable criteria identified in Section 1.500.) A patient day can not be counted as both a patient day and a bed hold day. For cost allocation purposes, all bed hold days at a nursing facility shall be reclassified at the ICF-2 level of care and all bed hold days in ICF-MR certified facilities shall be reclassified at the DD-3 level of care.

For cost allocation purposes, all Medicare patient days shall be classified as intensive skilled nursing days (ISN).

For cost allocation purposes, hospice patient days shall be treated as any Medicaid patient days for allocating all but direct care costs. To allocate direct care costs:

1. A residential level of care (ICF-4) shall be assigned to hospice patient days for persons who began to receive the hospice benefit after they were admitted to the facility; and

2. A medical level of care as appropriate shall be assigned to hospice patient days for persons who were receiving the hospice benefit at the time they were admitted to the facility.

All patient days meeting the ventilator dependent requirements in Section 4.691 shall be classified at the ventilator level of care.

1.316 Beds for Rate Setting

The beds for rate setting will be calculated as described in Section 3.040.

1.317 Medicaid Days

Only days of care for Medicaid residents that qualify for the nursing home fee-for-service benefit will be considered as Medicaid days for the special allowances for facilities operated by local units of government in Section 3.775. The facilities' Medicaid days for the exceptional Medicare/Medicaid utilization incentive in Section 3.651 shall include days of care for Family Care clients with a primary payor of Medicaid, Medicaid residents paid for by other states and residents funded by other Medicaid programs such as PACE, and Partnership in addition to days of care for fee-for-service residents.

1.400 NURSING HOME APPEALS BOARD

The Nursing Home Appeals Board is available for redress in the event a facility has extraordinary fiscal circumstances, as defined by statute. With the assistance of the Department, the Appeals Board shall develop written policies to ensure that the criteria required by statute are taken into account.

1.500 BED HOLD DAYS

Hospital bed hold days and therapeutic bed hold leave days will be paid at the ICF-2 rate for qualifying nursing facilities and at the DD3 rate for qualifying ICF-MR facilities. A maximum of 15 consecutive days is payable for each hospitalization leave. In order to qualify to bill for bed hold, facilities must meet occupancy criteria below. (Reference: HFS 107.09(3)(j), Wis. Adm. Code).

1.510 Bed Hold Occupancy Requirements

Hospital and/or therapeutic bed hold leave can be billed to the Medicaid Program if the certified provider's occupancy level is an average of 9.0 or fewer vacant licensed beds, or a 94.0% or greater occupancy rate during the calendar month prior to the bed hold leave days. If either test is met, then the subsequent month's bed hold days may be billed. Homes in start-up must meet bed hold occupancy provisions.

Any facility pursuing a phase-down of resident population due to a licensed bed reduction or a phase-out may be exempted from the above occupancy requirements. The Department must approve the phase-down or phase-out and its expected time period in writing and in advance before such exemption shall be allowed.

1.511 Combined Occupancy Test for Multiple Providers

A provider, at its option, may combine the occupancy calculation under Section 1.512 for two or more separately certified facilities if the facilities are located on the same or contiguous property and are fully owned by the same corporation, governmental unit or group of individuals. The election to combine or separate facilities for the occupancy can differ from one month to the next month. Distinct part facilities may also utilize this occupancy test.

1.512 Calculation of Occupancy for Bed Hold Billing

The occupancy in the month prior to the bed hold leave days shall be the basis for determining if the bed hold days in the subsequent month can be billed. Average vacant beds (for the " 9.0 or fewer" test) shall be determined by subtracting the month's average midnight census days from the sum of the average licensed beds less any restricted use beds of each certified provider for the month. The occupancy rate (for the "94.0% or greater occupancy rate" test) shall be determined by dividing the total patient days by the number of licensed bed-days for the month. For this calculation only, licensed bed-days shall not include any restricted use beds. For the purposes of this calculation, chargeable bed hold days shall be included as one full patient day.

1.530 Excludable Licensed Beds

Licensed beds may be reduced for (a) certain code violations, and (b) renovations in order to calculate the occupancy for bed hold billings. Excluded beds must meet one of the following criteria:

1. For code violations, excluded beds must be out-of-use due to life safety code violations cited by the Department. The Department must be notified of such beds.
2. For renovation, licensed beds must be out-of-use due to renovation projects. The excluded beds and the expected time period of the exclusion must be prior approved by the Department.
3. Restricted Use Beds. Restricted use beds are defined in Section 1.313.

1.540 Documentation

Sufficient documentation by a certified provider assuring the Department that requirements permitting billing for bed hold days have been met must be provided upon request. If a certified provider does not supply sufficient documentation, payments for unsupported billings may be recouped by the Department.

1.550 No Charge to Resident and Third Party

NO RESIDENT OR THIRD PARTY MAY BE CHARGED FOR COVERED BUT UNREIMBURSED BED HOLD OR THERAPEUTIC BED HOLD LEAVE DAYS OR SERVICES OF A MEDICAID RECIPIENT. Beds held for the following leaves are deemed to be Medicaid-covered services, even when a certified provider does not meet the above occupancy requirements:

- All hospital leaves of absence up through 15 days per hospitalization.
- All leaves for therapeutic visits.
- All leaves for therapeutic rehabilitative programs meeting the criteria under HFS 107.09(3)(j), Wis. Adm. Code.

1.600 RESOURCE ALLOCATION PROGRAM RATES AS A MAXIMUM

The per patient day property allowance stated in an application to the state's resource allocation program under Chapter 150, Wis. Stats., is the maximum allowable payment that may be granted by the Department for applications not involving the addition of beds for the first full year following completion of the project. In an application for approval of additional beds, the per patient day rate(s) stated in an application to the State's resource allocation program under Chapter 150, Wis. Stats., is the maximum allowable reimbursement that may be granted by the Department for the twelve months following licensure of the additional beds. If the Methods generates per patient day rates or per patient day property allowance that are less than those stated in the application, the Department shall use the lower rate(s) or allowance.

This section does not apply to ICF-MR facilities certified after June 30, 1988.

Resource Allocation Program maximums shall be applied for the first full year following completion of a project or the time period specified in the RAP approval.

1.700 CHAPTER 227 ADMINISTRATIVE HEARINGS

A facility may contest a final rate-setting action of the Department by writing to the Department of Administration's Division of Hearings and Appeals at P.O. Box 7875, Madison, WI 53707-7875. The rate approval letter issued to the facility by the Department is the formal written Notice of Action required by the state administrative code (Reference: HFS 106.12, Wis. Adm. Code). Those facilities with separate licensures as a nursing facility and as a free-standing ICF-MR (distinct part) will receive two rate letters. The request for hearing must be served within 15 days of receipt of a Notice of Action. It must contain a brief and plain statement identifying every matter or issue contested.

1.800 ADMINISTRATIVE REVIEWS

A facility may request an administrative review of the Department's cost finding decisions prior to the issuance of a rate approval letter. The request must be filed within 30 days of the facility's receipt of the notification of Medicaid nursing home rates and shall be subject to any other procedures or criteria developed by the Department. A facility's failure to file a timely request for an administrative review shall have no bearing on the facility's right to file a request for administrative hearing under Section 1.700 or an appeal to the Nursing Home Appeals Board under Section 1.400 upon issuance of the rate approval letter. All administrative reviews should be sent to:

David Lund, Nursing Home Section Chief
Division of Health Care Financing
P.O. Box 309
1 West Wilson
Madison, WI 53701-0309

1.900 MEDICARE BILLING

Facilities must bill Medicare for covered services and supplies. Facilities that bill Medicare for applicable Part B services must be dually-certified facilities, and must bill Medicare for Medicare-covered services or supplies prior to billing Medicaid. Providers are expected to bill the Medicare Part B program for any services or supplies for residents covered by that program. Should a provider not exhaust Medicare Part B sources of revenue, then the Department may offset that amount or an estimate of that amount which could be billed to Medicare Part B. This policy applies to facilities which do not bill Medicare at all or do not exhaust Medicare to the extent available for applicable Medicare third-party liability.

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SECTION 2.000 PAYMENT RATE ALLOWANCES DESCRIBED

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This Methods provides for payments which are divided into four major cost centers: Direct Care; Support Services; Property Tax and Property. Section 2.000 describes the types of services and costs generally covered by each cost center. The calculation of the payment allowances is described in Section 3.000.

2.100 DIRECT CARE ALLOWANCE

The direct care allowance shall reimburse for allowable facility expenses related to the provision of the following purchased and/or provided services and supplies, (which include, but are not limited to, staff wages, fringe benefits, and purchased services costs) up to maximums discussed in Section 3.100

2.110 Direct Care Nursing Services

Direct Care Nursing Services shall include all Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, QMRP-Nursing, Nurse's Assistant, Resident Living Staff, Feeding Assistants, Nurse Aide Training and Nurse Aide Training Supplies. Also included in Direct Care Nursing Services are nurse aides, nurse assistants and resident living staff. The Nurse's Assistant duties primarily involve skills that are taught in the instructional programs certified under Chapter HFS 129.05, Wis. Admin. Rules. Nurse's assistants are listed on the registry established under Chapter HFS 129.10, Wis. Admin. Rules, unless they have enrolled but not yet completed the required instructional program.

Feeding Assistants carry out limited tasks normally performed by nurse aides. The salary expenses for feeding assistants may be allowed as direct care if they have completed a specified training program adopted by this State and passed a standardized written competency quiz and a skills demonstration to include hand washing. The salary expenses and hours for feeding assistants not meeting the above requirements and all other single task employees should be included in the cost center that most represents the task performed other than direct care.

2.120 Other Direct Care Supplies and Services

Direct Care Supplies and Other Services shall include Ward Clerks, Non Billable – Physician, Active Treatment, Volunteer Coordinator, Social Service Personnel, Recreation Personnel, Religious Services and other special care, QMRP-Other, Purchased Laundry-Diaper, Diapers and Underpads, Catheter and Irrigation Supplies, Other Medical Supplies, Non Billable – Lab, Non Billable -X-Ray, Non Billable – Pharmacy, Non Billable – PT, Non Billable – OT. Non Billable – Speech, Non Billable – Dental, Non Billable – Psychiatric Services, Non Billable – Respiratory Services, Non Billable – Physician Supplies, QMRP-Nursing Supplies, QMRP-Other Supplies, Active Treatment Supplies, Volunteer Coordinator Supplies, Social Service Supplies, Recreation Supplies, Religious Services Supplies and other special care supplies. Non-billable services generally include those types of services which are provided to the facility as a whole instead of to an individual resident and/or which are not billable separately to the Medicaid Program per HFS 107, Wis. Adm. Code.

Direct Care Supplies and Other Services shall also include nonprescription charges approved by the Department to provide certain over-the-counter drugs, ordered by a physician. The allowable expenses may include the average wholesale price of the drugs and any pharmacy dispensing costs. Pharmacy dispensing costs shall not exceed 50% of the pharmacy's average wholesale price of the drug.

2.130 Exclusions

The cost of non-covered services identified in HFS 107, Wis. Adm. Code or Department policies shall not be reimbursed.

Expenses for the time to perform overhead activities related to billable therapy evaluations, procedures and modalities are not to be included in the rate calculation and are not to be considered in the cost report category of "non-billable expenses." Activities such as end-of-the-day clean-up time, transportation time, consultation and required paper reports are considered to be overhead activities.

Any nursing personnel, quality assurance personnel and/or therapy consultants who do not provide direct, hands on patient care shall be considered administrative and general expenses. Personnel who provide inservice training are exempted from this provision: see Section 2.135.

2.135 Inservice Training

The expense of providing inservice training for any of the above personnel shall be included in the calculation of the direct care allowance. Expenses relating to nurse aide training and competency evaluation programs (NAT/CEP) mandated by OBRA shall not be included in the daily rate; separate reimbursement is provided for the direct expenses incurred by a nursing facility for NAT/CEP that is required before an aide can be entered on the Nurse Aide Registry.

Section 5.100 of this Methods contains further guidelines on, and a list of, supplies which are intended to be included under this provision.

2.200 SUPPORT SERVICES ALLOWANCES

2.210 Dietary and Environmental Services

The support services allowance recognizes the allowable expenses to provide dietary and environmental services up to amounts payable under Section 3.200. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

2.211 Dietary Service Expenses

Dietary service expenses are those expenses directly related to the provision of meals to residents of the facility, including dietary supplements and dietician consultants.

2.212 Environmental Service Expenses

The support services allowance recognizes environmental service expenses related to the provision of maintenance, housekeeping, laundry and security services. Also included are expenses related to residents' personal laundry services, excluding personal dry cleaning services. Residents are NOT to be charged for the laundering of gowns.

2.250 Administrative and General Services

The support services allowance recognizes the allowable expenses for administrative, central office services and management services contract fees up to amounts payable under Section 3.210. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

2.251 Administrative Service Expenses

Administrative service expenses include those expenses related to the operation's overall management and administration, and other allowable expenses which cannot be appropriately recognized/reimbursed in other payment allowances or service areas. Expenses for the provision of general administrative, clerical, financial, accounting, purchasing, data processing, medical records and similar services are usually considered administrative expenses. Also included are allowable expenses for non-medical transportation, telephone, office supplies, training fees, license fees, insurance (except property, mortgage and general employee benefit insurance), working capital interest expense, amortized financing acquisition costs and other similar expenses. A nursing home may also include the allowable ownership and/or rental expenses of telephone equipment, and computer and electronic data processing equipment. (Inservice training, see 2.135) (Legal expenses, see 1.245) (Interest expense, see 1.270)

2.252 Central Office Costs

Administrative expenses allocated to the nursing home from centralized administrative units of a nursing home chain organization, multi entity or governmental agencies shall be recognized among administrative service expenses, including the centralized unit's allocated overhead expenses such as maintenance, utilities and depreciation. Salaries and fringe benefits for any nursing personnel, quality assurance personnel, and therapy consultants who report to a centralized administrative unit, but do not provide direct hands-

on patient care shall be included as central office costs. Expenses may be adjusted by the Department for unreasonable or unnecessary expenses or duplicative services.

2.253 Management Service Contract Fees

Management service contract fees shall be recognized among administrative service expenses, but may be adjusted by the Department for unreasonable or unnecessary levels of service, compensation, or duplicative services. Fees resulting from a percentage of cost or revenue arrangement will be disallowed by the Department, in whole or in part, according to the policy established by the Department. If actual management costs can be documented, those costs (subject to Medicaid allowability) may be substituted for the amount reported up to the amount actually paid.

2.254 Nursing Home Valuations

The cost of Department-required nursing home property valuations conducted by a Department-approved contractor shall be recognized among administrative service expenses.

2.260 Fuel and Other Utility Expense

The support services allowance recognizes the allowable facility expenses related to the provision of electricity, water and sewer services, and heating fuel including fuel oil, natural gas, LP gas, coal and other heating fuels.

2.400 PROPERTY TAX ALLOWANCE

2.410 Tax-Paying Facilities

The property tax allowance shall be a per patient per day amount for allowable property tax expense. Allowable property tax expense shall exclude any state property tax credit and any special assessments for capital improvements, such as sewers, water mains and pavements. Whenever exemptions to property tax are legally available, the provider shall be expected to pursue such exemptions. If the provider does not pursue available exemptions, the expenses incurred for property tax shall not be allowed.

2.420 Tax-Exempt Facilities

The property tax allowance for tax-exempt facilities may include a per patient per day amount for the cost of needed municipal services. Includable municipal services will be limited to those services which are financed through the municipality's property tax and which are provided by the municipality to property taxpayers without levying a special fee for the service. A tax-exempt facility may be paying a municipal service fee to the municipality for the services or may provide the service and incur the cost in their own operation.

2.500 PROPERTY PAYMENT ALLOWANCE

The property payment allowance will be a per patient day amount based upon the value of a facility's buildings as estimated by a commercial estimator, target amounts based on service factors established by the Department, and the nursing home's allowable property-related expenses. The estimation will conform with guidelines determined by the Department. This allowance covers, in whole or in part, the nursing home's expenses related to ownership and/or rental of the land, land improvements, buildings, fixed and movable equipment, and other physical assets.

2.700 PROVIDER INCENTIVES

2.710 Exceptional Medicaid/Medicare Utilization Incentive

Nursing homes, other than those operated by a governmental entity, with exceptional Medicaid/Medicare utilization, described in Section 3.651, may receive the payment incentive. A non-profit corporation operating a facility, which in turn is controlled exclusively by a municipality, will be viewed as a government entity. The primary source of ownership information is the owner identified on the operating license issued by the Department. Ownership status is determined as of the last day of the cost report. If a

governmental facility changes ownership status, it will not be eligible for this incentive until such time that the change in ownership status has been reflected on the cost report used to set the rate for the applicable rate year.

2.720 Private Room Incentive

Nursing homes may be eligible to receive a Basic Private Room Incentive (BPRI), or a Replacement Private Room Incentive (RPPRI). To determine eligibility, nursing homes must meet licensed bed and patient day requirements. To receive an incentive, nursing homes must submit an affidavit to the department stating that during the reimbursement year they will not charge Medicaid residents the surcharge for private rooms allowed under HFS 105.09(4)(k) as of the date the incentive would be effective. The affidavit must be received prior to the effective date of the incentive unless the Department approves an alternate cost reporting period under Section 1.302. A private room is a room licensed for single occupancy.

1. Basic Private Room Incentive. Nursing homes which meet the both exceptional Medicaid/Medicare utilization, see Plan Section 2.710, and have an extraordinary number of private rooms equal to the private room percentage (PRP) listed in Plan Section 3.653(a), may receive a payment incentive. This Basic Private Room Incentive is based on the percentage of private rooms to total licensed beds. Licensed bed and private room requirements are listed in Plan Section 3.653(a).

2. The Replacement Private Room Incentive (RPPRI) is for facilities replacing 100% of the patient rooms subsequent to July 1, 2000, and will be effective the first day of service in the replacement facility or July 1, 2006, whichever is later. The replacement facility must meet the exceptional Medicaid/Medicare utilization in Plan Section 2.710 and the private room percentage (PRP) listed in Plan Section 3.653(b). If a facility does not replace 100% of the patient rooms they may still qualify for the BPRI.

2.730 Energy Savings Incentive

If a facility completes a remodeling or renovation project specifically designed to reduce consumption of electricity or heating fuels, or to reduce their electricity or heating fuel rates per unit of energy, the facility may receive an incentive per the calculation method in Section 3.652. In order to qualify for this incentive, the project must have been approved in advance by the Department. During the approval process the Department will consider:

1. The projected savings from the project based on an independent analysis to be provided by the facility. Such analysis may be provided by a public utility or an independent contractor qualified in engineering, architecture, or energy audits.

2. The projected cost of the project.

3. The combined simple payback for all projects proposed for the facility must be less than ten years.

Allowable costs for the incentive will be the lower of: 1) the amount approved in advance by the Department, or 2) the cost of equipment, installation, engineering, energy management and consultant fees prior to rebates. Interest, bond discounts, premiums and financial and/or auditing fees will not be an allowable cost for the incentive.

Replacement boilers that are not part of a co-generation project, replacement central air conditioners, condensers and windows, if included in a project approved or started after July 1, 2000, are excluded from this incentive, although fuel conversion projects are valid projects for this incentive.

The incentive will be available for all projects approved or received by the Department no later than September 30, 2003.

2.740 Medicaid Access Incentive

The Medicaid access incentive is provided to facilitate access to nursing home care for all Medicaid recipients. The incentive will vary based on the facilities certification.

2.800 SPECIALIZED PSYCHIATRIC REHABILITATIVE SERVICES

Specialized Psychiatric Rehabilitative Services Supplement Specialized psychiatric rehabilitative services (SPRS) are those services as determined by the comprehensive assessment and the (SPRS) care plan, to prevent avoidable physical and mental deterioration and to assist clients in obtaining or maintaining their highest practicable level of functional and psycho-social well being. SPRS shall include: 1) The client's regular participation, in accordance with their SPRS care plan, in professionally developed and supervised

activities, experiences and therapies. 2) Activities, experiences and therapies that reduce the resident's psychiatric and behavioral symptoms, improve the level of independent functioning, and achieve a functional level that permits reduction in the need for intensive mental health services.

To qualify for the supplemental payment the nursing home must prepare a SPRS care plan that defines measurable goals and objectives for the client's specialized psychiatric rehabilitative services. The SPRS care plan must be reviewed and updated at least annually or as needed to appropriately reflect change in the client's need for mental health services. If the nursing home, based on their assessment, believes that specialized rehabilitative services are no longer required, they should request a resident review from the PASARR contractor. A Level II PASARR screen that indicates that nursing facility placement is appropriate and that SPRS is needed, is required every two years to maintain eligibility for the supplemental payment.

SECTION 3.000 CALCULATION OF PAYMENT ALLOWANCES

3.001 Introduction

The payment allowance calculations are described in this section. For the payment system, the calculations of the allowances are on a per patient day basis.

3.040 Beds for Rate Setting

The beds for rate setting will be calculated as follows:

- Licensed beds on the last day of the base cost reporting period in Section 1.302;
- Less the beds in the bed bank on the last day of the base cost reporting period in Section 1.302; and
- Less any additional beds deposited after the close of the base cost reporting period in Section 1.302 but before July 1, 2006.

3.050 Adjustments

1. Restricted use beds with a restricted use license issued before July 1, 1995 will be excluded from the beds for rate setting.
2. Beds that are part of RAP projects, as defined in Section 1.240, will be excluded from Beds for Rate Setting if the project(s) is completed by July 1, 2000.
3. Facilities that have qualified for a Section 4.800 adjustment relating to beds out-of-use for renovation projects shall also qualify for a reduction to beds for rate setting. The reduction shall be equal to the monthly weighted average of the beds out-of-use during the cost report period used for rate setting.

3.060 Bed Bank

The Department shall exclude banked nursing home beds from the beds for rate setting (Section 3.040).
For bed bank requests submitted after June 30, 2006, the bed adjustment will be effective July 1, 2007, subject to the Methods then in effect.

If a bed license is split after the end of the cost report period, causing a transfer of beds between more than one facility and there are banked beds on the license, a new rate will be calculated for each facility, effective July 1, 2007, subject to the Methods then in effect, unless Sections 4.400 or 4.500 apply.

3.061 Bed Bank Reductions and Resumption

The Department shall allow the nursing home to exercise the right to resume use of banked beds, unless PERMANENTLY reduced by s. 49.45(6m), with licensure resumption contingent upon receipt of a 18 month prior notice to the Department. Permanent reduction shall occur if any banked beds remain delicensed under this paragraph at the rate of 10% of all remaining delicensed banked beds or 25% of one bed, whichever is greater.

3.062 Bed Bank Restrictions

1. If any of the provisions of Section 4.500 are being applied during the payment rate year to a facility that phases down or closes, then that facility does not qualify for banking of beds.

2. The total beds for rate setting and banked beds cannot exceed the total licensed beds.

3. Banked beds cannot be occupied by any resident. If such use is discovered and such use would raise the number of occupied beds above the number of licensed beds minus banked beds, all beds banked by the facility will be expunged from the bank and the banked beds will be delicensed permanently.

If such use is discovered but does not exceed the number of licensed beds minus banked beds, the facility has 30 days to correct the occupancy or the beds involved will be expunged from the bed bank and will be delicensed permanently.

4. If banked beds are part of a phase down, the beds will be expunged from the bed bank.

3.100 DIRECT CARE ALLOWANCE

SFY07 is a transition period from using the Skilled and Intermediate levels of care to using Resource Utilization Groups (RUGs) in both the rate calculation and to establish a blended rate for payment of Medicaid residents during the reimbursement period. The DD rates will continue to be used for residents in ICFsMR and for residents that require specialized services in nursing facilities. The level of care case mix indices has been rescaled to have the same average value across WI Medicaid residents as the RUGs case mix indices to accommodate a blended case mix index during the transition period. The RUGs case mix index is determined using the RUGs 34 grouper (Version 5.20) with index maximization on the last day of the calendar quarter for residents at the medical care levels. In addition to the RUGs group, all residents at the medical levels of care must meet the minimum definition for Limited (ICF2) nursing care in HFS132.13 to be eligible for nursing home payments.

To implement the transition several features have been incorporated into the direct care calculation. A single blended allowance will be computed for all non-DD in-house residents. This blended allowance will be based on a case mix weighted 50% by the case mix index (CMI) for the levels of care and 50% for the RUGs CMI. An alternate direct care calculation will be available for most facilities. An alternate direct care base will be used with the facility's level of care CMI (when available) to determine an alternate direct care allowance.

A supplement for behavior and cognitive impairment has also been added to the direct care allowance. Using selected variables from the MDS assessment for Medicaid residents, a behavior score is calculated for each facility. This behavior score and a base allowance is used to calculate the behavior supplement that is added to each facilities Medicaid rate for non-DD residents.

3.110 Types of Payment Rates

The payment allowance for direct care will be computed for each facility so as to establish a blended rate for non-DD care levels:

1. A rate for the combination of skilled care (SNF), intense skilled nursing (ISN), intermediate care (ICF 1), limited care (ICF 2), personal care (ICF 3) and residential care (ICF4).

The payment allowance for direct care for residents with developmental disabilities that require specialized services will be computed for each facility so as to establish a rate for each of the following levels of care

1 A developmentally disabled 1A rate (DD 1A).
2. A developmentally disabled 1B rate (DD 1B).
3. A developmentally disabled 2 rate (DD 2).
4. A developmentally disabled 3 rate (DD 3).

Payment allowances for direct care for non-DD and DD residents on bed-hold will establish corresponding rates for:
1. Non-DD bed-hold rate
2. DD bed-hold rate

3.115 Patient Days

Patient days are defined in Section 1.315.

3.118 ICF-MR Facilities

A facility which has a distinct part certified as ICF-MR shall submit a combined cost report under Section 1.176. Separate rates shall be calculated for the ICF-MR distinct part and those NF distinct parts which are covered by the combined cost report.

3.120 Method of Computation of Direct Care Allowance

3.121 Inflation Adjusted Expense

The facility's actual allowable direct care expenses for staff wages, fringe benefits, purchased services and supplies shall be inflated/ deflated from the cost reporting period to the common period using the inflation factors in Section 5.310. Dividing the sum of these inflated expenses by patient days yields per day inflated expenses.

3.122 Case Mix Indices

The direct care allowance calculation uses several case mix index (CMI) values for the facility. These CMI's relate to resident acuity during the cost reporting period and anticipated during the reimbursement period. Some CMI's are associated with the all-resident population, while others relate only to the Medicaid resident population or a portion of that population.

The facility's level of care Case Mix Index (LOCCMI) is the average of the case mix values in Section 5.420 weighted by the patient days for each level in the reporting period.

The RUGs CMI (RUGCMI) is a blended value for non-DD and DD residents during the cost reporting period. The non-DD component is based on the average RUG-34 case mix index values in section 5.420 for the last days of those calendar quarters (picture dates) in section 5.421 that occur during the cost reporting period. The DD component is based on the reported patient days by DD level of care and the corresponding level of care CMI values in 5.420. The non-DD and DD case mix components are weighted by the non-DD and DD reported patient days.

The primary case mix index (PRICMI) is weighted 50% by the level of care LOCCMI and 50% by the RUGs CMI. Hence,

PRICMI = [(0.5 * LOCCMI) +(0.5 * RUGCMI)]

The alternate case mix index ALTCMI is 100% of the level of care CMI. Hence,

ALTCMI = LOCCMI.

The facility's reimbursement period level of care Case Mix Index (T19_LOCCMI) is the average of the case mix values in Section 5.420 weighted by the distribution of in-house Medicaid residents on 12/31/2005.

The facility's reimbursement period level of care Case Mix Index for Non-DD residents (NonDD_T19_LOCCMI) is the average of the case mix values in Section 5.420 weighted by the distribution of in-house Medicaid Non-DD residents on 12/31/2005.

The reimbursement period RUGs CMI (T19_RUGCMI) is a blended value for non-DD and DD Medicaid residents on the Picture Date. The non-DD component (NonDD_T19_RUGCMI) is based on the average RUG-34 case mix index values in section 5.420 for Medicaid in-house non-DD residents on the Picture Date. The DD component is based on the average level of care case mix values in section 5.420 for Medicaid in-house DD residents on the Picture Date. The non-DD and DD case mix components are weighted by the Medicaid in-house non-DD and DD residents on Picture Date.

The primary reimbursement period case mix index (T19_PRICMI) is weighted 50% by the level of care and 50% by the RUGs CMI. Hence,

T19_PRICMI = [(0.5 * T19_LOCCMI) +(0.5 * T19_RUGCMI)]

The alternate reimbursement period case mix index (T19_ALTCMI) is 100% of the level of care CMI. Hence,

T19_ALTCMI = T19_LOCCMI.

The primary reimbursement period case mix index for Non-DD residents (NonDD_T19_PRICMI) is weighted 50% by the level of care CMI and 50% by the RUG CMI. Hence,

NonDD_T19_PRICMI = [(0.5 * NonDD_T19_LOCCMI) +(0.5 * NonDD_T19_RUGCMI)]

The behavior/cognitive impairment score (BEHCI) for the facility is based on selected items from the most recent full MDS assessment for non-DD Medicaid residents on the Picture Date.

The RUGs portions of T19_PRICMI and NonDD_T19_PRICMI will be calculated twice, once for each of the two Picture Dates indicated in Section 5.422. The level of care portions of these CMIs will be calculated only once with a Picture Date of 12/31/2005. The behavior/cognitive impairment score will also be calculated twice according to Section 5.422. The resulting rates from each calculation Picture Date will become effective according to the Rate Effective Dates in Section 5.422.

3.123 Adjustment to Case Mix Index

Facilities that have beds for rate setting (Section 3.040) of fifty beds or less and are certified only as a nursing facility will have a 20% increase in their case mix indices. Facilities that are certified as ICF-MR facilities either in whole or in part are not eligible to have its case mix index adjusted under this section.

3.124 Nursing Services Allowance

1. Primary Nursing Services Allowance

    a. The facility's Primary Nursing Services Target (PRINST) is the product of PRICMI times the Primary Nursing Services Base in Section 5.430, times the Labor Factor in Section 5.410. Hence,

    PRINST =PRICMI *Primary Nursing Services Base* Labor Factor.

    b. E= Expense per patient day per Section 3.121

    Primary Common Period Allowance (PriCom)

    If the expense (E) is equal to or greater than the target (PRINST),

    PriCom = PRINST

    If the expense (E) is less than the target,

    PriCom = E

    The primary inflation increment is the facility's PRICMI times the Nursing Services Inflation Increment in Section 5.440.

    Primary Inflation Increment = PRICMI * Nursing Services Inflation Increment

    Primary Nursing Services Reimbursement Period Allowance = PriCom + Primary Nursing Services Inflation Increment.

2. Alternate Nursing Services Allowance

    a. The facility's alternate Nursing Services Target (ALTNST) is the product of ALTCMI times the Alternate Nursing Services Base in Section 5.430, times the Labor Factor in Section 5.410. Hence,

    ALTNST =ALTCMI *Alternate Nursing Services Base* Labor Factor.

    b. E= Expense per patient day per Section 3.121

    Alternate Common Period Allowance (AltCom)

    If the expense (E) is equal to or greater than the target (ALTNST),

    AltCom = ALTNST

    If the expense (E) is less than the target,

    AltCom = E

    The alternate inflation increment is the facility's ALTCMI times the Nursing Services Inflation Increment in Section 5.440.

    Alternate Inflation Increment = ALTCMI * Nursing Services Inflation Increment

    Alternate Nursing Services Reimbursement Period Allowance = AltCom + Alternate Nursing Services Inflation Increment.

3.126 Other Supplies and Services Allowance

1. Primary Other Supplies and Services Allowance
    a. The facility's Primary Other Supplies and Services Common Period Allowance is the product of the Primary Other Supplies and Services Base (PRIBASE) in section 5.430 and PRICMI.
    b. The Primary Supplies and Service Inflation Increment is the product of the Supplies and Services Inflation Increment in section 5.440 (OTHINC) and PRICMI. Hence,

Primary Other Allowance = (PRIBASE * PRICMI) + (OTHINC *PRICMI)

2. Alternate Other Supplies and Service Allowance
    a. The facilities Alternate Other Supplies and Services Common Period Allowance is the product of the Alternate Other Supplies and Services Base (ALTBASE) in section 5.430 and ALTCMI.
    b. The Alternate Supplies and Service Inflation Increment is the product of the Supplies and Services Inflation Increment in section 5.440 (OTHINC) and ALTCMI. Hence,

Alternate Other Allowance = (ALTBASE * ALTCMI) + (OTHINC *ALTCMI)

3.127 Behavior and Cognitive Impairment Allowance

Selected variables from the MDS assessments are used to compute a behavior/cogitative impairment index for the Medicaid residents in each facility for the periods in section 5.422. This behavior/cognitive impairment score (BEHCI) and the base allowance in section 5.460 are used to calculate the behavior supplement that is added to each facilities Medicaid rate for non-DD residents. Hence,

Behavior/Cognitive Impairment Allowance = BEHCI * Behavior/Cognitive Impairment Base in Section 5.460

3.128 Direct Care Reimbursement Period Allowance

The primary direct care allowance is the sum of the primary nursing services allowance and the primary other allowance, divided by PRICMI and multiplied by T19_PRICMI.

The alternate direct care allowance is the sum of the alternate nursing services allowance and the alternate other allowance, divided by ALTCMI and multiplied by T19_ALTCMI.

The average direct care reimbursement period allowance will be the greater of the primary and alternate direct care allowances.

The RUG components of the case mix indices and the behavior/cogitative impairment score will be recalculated using Section 5.422.

3.129 Allocation by Level of Care

This allocation is done by dividing the average direct care reimbursement period allowance from Section 3.128 by T19_PRICMI (prior to the 20% adjustment in Section 3.123) and multiplying the result in turn by each rate classification's primary case mix index. For the non-DD rate classes, the behavior/cognitive impairment allowance from Section 3.127 will be added. The primary case mix index for each rate classification is determined as follows:

1. For DD in-house rate classes, the primary case mix index is equal to the level of care CMI in Section 5.420.
2. For DD bedhold, the primary case mix index is equal to the DD3 in-house CMI.
3. For the Non-DD in-house rate class, the primary case mix index is 50% of NonDD_T19_LOCCMI and 50% of NonDD_T19_RUGCMI, both computed prior to any 20% adjustment from Section 3.123.
4. For Non-DD bedhold, the primary case mix index is 50% of the ICF2 level of care CMI and 50% of the RUGs bedhold CMI shown in Section 5.420.

If the facility average direct care reimbursement period allowance is equal to the alternate direct care allowance on both Picture Dates, the schedule of direct care allowances will be updated only for non-DD changes in the behavior/cognitive impairment allowance.

3.130 Payment for Specialized Psychiatric Rehabilitation Services

Facilities that provide Specialized Psychiatric Rehabilitation Services per Section 2.800 can provide the Department with adequate documentation of services provided to residents each month. The facilities will receive payment separately from the rate per Section 5.950.

3.140 Direct Care Payment for facilities with Special Rate Adjustments and Recalculations on or after July 1, 2006

The 12/31/2005 level-of-care case mix data for the direct care level-of-care to RUGs transition are not available or not representative for rate adjustments for new facilities in section 4.300, a significant increase in licensed bed in section 4.400, or a change in certification or licensure that occurs on or after July 1, 2006. The data for a transition is also not reliable for facilities with a significant decrease in licensed beds in section 4.500 where the phase down period ends on or after July 1, 2006. The nursing services allowance and the other supplies and services allowance will be calculated for these facilities without reference to the facilities' cost and using only the RUGs case mix indices. Hence,

The nursing service base is the sum of the primary nursing services base in section 5.430 plus the inflation increment in section 5.440. The nursing service labor adjusted base is the nursing service base times the labor factor in section 5.410. The reimbursement period nursing service allowance for Non DD residents is the labor adjusted base times the Non DD T19RUG CMI (after any 20% adjustment from Section 2.123). The DD and bed hold allowances are equal to the labor adjusted base times the appropriate case mix weight in section 5.420. (The case mix weight for DD bed hold is the DD3 in-house CMI. The case mix weight for Non DD bed hold is the RUGs bed hold CMI.)

The other supplies and services base is the sum of the primary other supplies and services base in section 5.430 plus the inflation increment in section 5.440. The reimbursement period other supplies and service allowance for Non DD residents is the other supplies and service base times the Non DD T19RUG CMI (after any 20% adjustment from Section 2.123). The DD and bed hold allowances are equal to the other supplies and services base times the appropriate case mix weight in section 5.420.

The behavior and cognitive impairment allowance in section 3.128 will be added to the Non DD in-house and bed hold allowances.

The picture dates for the RUGs case mix indices will be September 30, 2006; December 31, 2006; March 31, 2007 and June 30 2007. The direct care allowance will be calculated using the earliest picture date subsequent to the effective date of the payment rate

3.150 Review and Correction of the Case Mix Indices

The Department will calculate the case mix indices in section 3.122 from information in the MDS data base, Medicaid paid claims information, the base cost report and supplemental cost reports. The department will provide summary information supporting the basis of the CMIs to the provider. The facility may request resident level data from the calculation of the CMIs. The facility may request corrections supported by resident level data for the period. Any correction will result in a recalculation of the level of care CMI, the RUGs CMI and the behavior/cognitive impairment score for the period. The Department may apply the material adjustment standard in section 4.120 to corrections in the CMI. Any information exchanged with the Department and the facility under this process will be considered protected medical information.

3.200 SUPPORT SERVICES ALLOWANCE

3.210 Method of Calculation

Payment for allowable expenses associated with the facility's provision of support services shall be determined according to the following formula:

P = Support services payment allowance

T = Target as described in Section 5.510

I = Per patient day increment under Section 5.510

$$P = T + I$$

3.211 On-Site Water and Sewer Plants

For facilities which have on-site water and sewer plants, costs associated with maintaining such operations will be included in the support services payment allowance.

3.212 Seasonal Cost Variations

If a facility's base cost report is not for a twelve-month period, the heating fuel and utility expense shall be adjusted for seasonal cost variations. Whenever possible, a twelve-month period for heating fuel and utility expense should be used with such expenses adjusted to the time period covered by the patient day count. If twelve months cannot be acquired, then heating fuel expenses should be adjusted to a twelve-month period based on heating degree days.

3.400 PROPERTY TAX ALLOWANCE

3.410 Tax-Paying Facilities

Allowable property tax expense shall be based on the tax due for payment by the provider (or the lessor of the building) in the calendar year in which the payment rate year begins. For example, a July 2006 payment rate will include the amount of the December 2005 property tax bill increased by the inflation factor in Section 5.700 to adjust payment and expense to the payment rate year. Alternative cost reporting may be allowed under provisions in Section 4.000.

3.420 Tax-Exempt Facilities

The property tax allowance for tax-exempt providers may include the cost of needed municipal services. For municipal service fees, the expense shall be the expense for municipal services provided to the facility in the calendar year prior to the beginning of the payment rate year as appropriately accrued to that period. The operating expense will be inflated/deflated to the common period by the dietary and environmental services inflation factor. Alternative cost reporting may be allowed under provisions in Section 4.000. The payment rate will include the inflated amount increased by the inflation factor in Section 5.700 to adjust payment and expense to the payment rate year. For operating expenses incurred by the facility, the expense will be from the cost reporting period used for other payment allowances.

3.500 PROPERTY PAYMENT ALLOWANCE

3.510 General

The property payment allowance will be a per patient day amount based on: the equalized value of the nursing home; target amounts based on service factors established by the Department; and the nursing home's allowable property-related expenses. This allowance is intended to provide payment for ownership, and/or rental of land, land improvements, buildings, fixed and movable equipment and any other long-term, physical assets. The asset value of nursing homes acquired at nominal or no cost shall be allowed at the lesser of fair market value or net book value of the owner last participating in the Medicaid program. Depreciation life shall be at the greater of 20 years or balance of 35 years from date of construction. The minimum estimated useful life of used movable equipment will be 5 years. This life will be applied to the composite value of the acquired equipment.

3.520 Allowable Property-Related Expenses

Allowable property-related expenses include: depreciation, interest on plant asset loans, amortization of construction-related costs, amortization of bond discount and premium, lease and rental expenses, and property and mortgage insurance. These costs must be reported in accordance with generally accepted accounting principles (GAAP) and must be necessary for providing nursing home patient care.

The cost reports for the base cost reporting periods and alternative cost reporting periods, as defined in Sections 1.302 and 4.000, will be the source for the information used to determine allowable property-related expenses.

Allowable costs will be adjusted to reflect any limitation on the revaluation of capital assets or lease limitations required under Sections 3.522 or 3.523.

3.521 Maximum on Allowable Property-Related Expenses

Annual allowable property-related expenses will be limited to 15% of the equalized value of the facility.

3.522 Changes of Ownership

If a facility changes ownership on or after October 1, 1985, a change in valuation will be allowed the new owner of the facility. The new owner's valuation will be the lesser of the purchase price or maximum valuation. The maximum valuation is calculated by multiplying the sellers annual asset acquisition costs by year(s) of acquisition times the lesser of one-half of the percentage increase, measured over the same period of time, in the Consumer Price Index (CPI) for All Urban Consumers (United States city average) or the Dodge Construction Index (DCI) applied from the year(s) of acquisition to the date of the sale. The year(s) of acquisition is/are the year(s) the assets were purchased or constructed by the seller of the facility.

If either the seller or the buyer cannot support the individual assets acquired, the historic asset acquisition cost(s) and/or the date(s) of asset acquisition, the following procedure will be followed to impute the maximum allowable value related to capital assets:

1. The ending balance of the total capitalized historical cost of all depreciable assets, from the last available fiscal year cost report of the seller, will be the base value;

2. The ending balance of accumulated depreciation of all depreciable assets, from the same cost reporting period, will be divided by the reported depreciation expense (annualized, if necessary) to impute average years of ownership;

3. The lesser percentage of CPI or DPI described in the first paragraph of this Section 3.522 will be determined based on the imputed average years of ownership and applied to the base value of all assets acquired to calculate an initial maximum; and

4. This initial maximum will be compared to 108% of the equalized value described in Section 3.531 below and the lesser value allowed as the maximum allowable value related to all assets.

Where no cost report information is available, the maximum allowable value will be 108% of the equalized value from Section 3.531.

If more than one nursing home is purchased at the same time, the purchase price of all property related assets will be allocated proportionately to all purchased assets based upon an independent uniform appraisal method chosen by the purchasing provider.

This section does not apply to changes of ownership pursuant to an enforceable agreement entered into prior to October 1, 1985.

The costs of acquiring the rights to licensed beds from another provider are non-reimbursable.

3.522(a) Expenses Associated with Change of Ownership Limited by Section 3.522

If a facility's valuation is limited under Section 3.522 the associated depreciation, amortization, and interest expenses will also be limited. Reported depreciation, interest and amortization expenses will be multiplied by the ratio of the above maximum to the actual purchase price to determine allowable expense. If the valuation of assets of the new owner are not limited to the maximum in Section 3.522 actual costs will be allowed subject to Section 3.520 allowability.

3.523 Lease and Rental Expense

1. Lease Maximum determination for on-going leases. If a facility was leased prior to the current cost reporting period, the maximum allowable lease expense for the current cost report period, will be limited to the lower of the actual lease payments or the total of the allowable lease expenses from the previous years cost reporting period multiplied by one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for all Urban Consumers (United States City average).

2. Lease Maximum determination for previously owned but never leased. If a facility is leased during the current cost reporting period but was not previously leased, the allowable maximum lease expense will be determined by reference to the current owners year(s) of acquisition of the facility's fixed assets to the current cost reporting period. The year(s) of acquisition is/are the year(s) the facility was purchased or constructed by the owner. The lease maximum will be determined by: a) If the facility is still owned by the original provider that constructed the facility- divide the original cost(s) of construction/acquisition adjusted by one-half of the Consumer Price Index, by the original costs(s) of construction/acquisition; or b) If the facility was previously purchased – divide the allowable purchase price adjusted by one-half of the Consumer Price Index plus capital additions, by the allowable purchase price plus capital additions from the cost report used for rate setting prior to the lease (per Section 3.522).

This ratio will then be applied to the allowable property expenses, related to the assets now leased, and that were included in rates effective June 30, 2006, to determine the maximum allowable property expense subject to number 5 below and Section 3.523.(a). The lower of actual or calculated maximum lease expense shall be used for determining the property reimbursement under Section 3.530.

3. Lease Maximum determination for new or replacement facilities. For new or replacement facilities that began operation in the cost report used for 2006-2007 rate setting, the lease expense paid is the maximum allowable for 2006-2007 subject to all other cost standards and formula limitations.

4. Lease determination for a sale and lease back. For purposes of this section, an unrelated party sale and lease back transaction will be limited by the percentage increase that would be applied if the facility had been leased prior to the base cost reporting period. The lease maximum shall be determined by applying one-half the increase in the CPI from the year of the sale to the allowed reimbursable property expenses for the assets that are now leased from the year before the sale.

5. General provisions of allowable lease determinations. This limitation will only apply to lease expense and other capital costs as of the date of lease inception. It will not apply to depreciation, interest, lease and rental or other property costs on assets, whether the lessee or lessor acquired the assets after lease inception, such as the purchase or leasing of new equipment or leasehold improvements.

If a facility is unable to provide adequate support of the dates of asset acquisition, the procedure under Section 3.522 for imputing average years of ownership may be applied.

Lease expense includes the actual payments required under the lease contract. Lease expenses determined under the capitalized lease method of Financial Accounting Standards Board Statement No. 13 will not be recognized.

The costs of acquiring existing leasehold rights are not allowable.

3.523(a) For leases existing prior to the cost report used for 2006-2007 rates, the limit calculated under this section will be increased for depreciation and interest expenses incurred by a lessor for leasehold improvements completed on or after July 1, 2006. The amount of increase will be calculated as if the lessee had made the improvements. This increase will be allowed only after a written agreement by the lessor has been received by the Department guaranteeing access to all records relating to the claimed expenses.

3.524 New Facilities, Replacement Facilities and Significant Licensed Bed Increases or Decreases on or after July 1, 2006

For new facilities licensed on or after July 1, 2006, and facilities with significant licensed bed increases or decreases on or after July 1, 2006 (as defined in Sections 1.305 and 1.304 respectively), the property payment allowance will be recalculated using the cost reporting periods and procedures described in Sections 4.300, 4.400, or 4.500.

The property payment allowance will also be recalculated when a facility has replaced a significant number of licensed beds. ("Replacement" is defined in Section 1.306.) (A "significant" replacement is defined as the replacement of the lesser of: (1) 25% of licensed bed capacity or (2) 50 beds.) When a significant replacement has occurred, the property payment allowance will be based on at least a six-month cost reporting period which begins within five months after the first of the month following licensure of the replacement bed area. The adjusted property payment allowance will be effective as of the date of licensure. No phase-in or start-up provisions will apply to property payment allowances for facilities receiving adjustments for replacement facilities.

3.525 Depreciation and Amortization

1. Amortized A & G expenses. Amortization of the costs related to acquiring financing (i.e., bond issuance costs, bond placement fees, and letter of credit fees) are not considered property-related expenses but are allowable expenses under the administrative and general component. Financing fees include such items as, but not limited to, finder's fees, credit checks, origination fees, appraisal fees, feasibility studies, and loan application fees. Amortization of such fees is allowable in A & G. Write off of the entire unamortized discount (premium) and unamortized fees associated with refinanced debt will be allowed as of the date of refinancing as recognized for cost reporting purposes.

2. Amortized property expenses. Amortization of bond discounts and premiums are to be considered an element of interest expense**.** Letter of credit fees related to a letter of credit used only as collateral for obtaining long term financing (bonds, mortgages, etc.) shall be allowed as property.

3. Depreciation expense. Depreciation expense must be calculated under a straight-line method over a useful life, consistent with generally accepted accounting principles (GAAP). Useful lives will be determined by reference to the useful lives guidelines published by the American Hospital Association.

3.525(a) Minimum Useful Life for Plant Assets

Depreciation for either the initial construction of buildings or building additions (including fixed equipment and land improvements) must be based on a minimum useful life of 35 years from the earlier of: 1) the date of initial licensure of the facility as a nursing home or other health care facility, or 2) the date of initial occupancy. Remodeling projects of existing licensed facilities will be depreciated according to American Hospital Association (AHA) guidelines for each of the individual components of the project. A minimum estimated useful life of 20 years will be applied to facilities purchased after July 1, 1988. New movable equipment will be depreciated according to AHA guidelines. The minimum estimated useful life for purchases of used movable equipment will be 5 years. This life will be applied to the composite value of the purchased equipment.

3.525(b) Expenses Directly Related to Establishing Units for Services to Ventilator Dependent Residents

A facility's additional expenses for depreciation and interest directly related to establishing a unit for ventilator dependent residents may be exempted from the limitations and maximums under Sections 3.500. "Directly related" means that the costs have been incurred solely as a result of creating this unit and the equipment acquired or remodeling performed benefits only this unit. Prior approval by the Department (i.e., Administrator of the Division of Health Care Financing) of the remodeling project or equipment acquisition is required. This adjustment is only available for projects completed after July 1, 1993.

3.526 Interest Expense

Generally, interest expense on loans for acquisition of nursing home plant assets and equipment is an allowable property-related expense. Interest expense must be reasonable and necessary to be considered allowable. "Necessary" means that the interest is incurred on a loan necessary to satisfy a financial need and for a purpose reasonably related to nursing home resident care. Allowable interest expense on debt incurred for the acquisition of land, land improvements, buildings, leasehold improvements, and fixed and movable equipment related to nursing home patient care is a property-related expense.

3.526(a) Basis for Allowable Interest Expense

Allowable interest expense is based on:

1. Proper accrual under Section 1.302;
2. Recognizable debt balances under Section 3.526(b);
3. A "systematic reduction of debt" under Section 3.526(c);
4. Financing terms that would be incurred by a "prudent buyer" at the time a debt is created; and
5. The net amount remaining after investment income is offset.

3.526(b) Recognizable Debt Balances

Interest expense will be allowed only on debts which:

First, are for the acquisition of the plant assets listed in Section 3.526 that are directly related to nursing home patient care;

Second, have been limited or allocated, if necessary, under Section 3.522; and

Third, are for the original asset acquisition plus the second and third cost report year after a loan has been taken out, we will add the amount of asset purchases to the assets purchased the first year of the loan to determine maximum financing allowed. The recognized debt balance will be adjusted when the additional assets flow through the aforementioned cost reports.

Fourth, do not exceed 110% of Equalized Value per Section 3.531(b).

3.526(c) Systematic Reduction of Debt

Allowable interest expense may not exceed the amount which would have been incurred under a systematic reduction of debt. The calculation of this limitation varies based on whether a facility makes at least annual principal payments or deposits to a segregated interest-bearing account.

If a facility makes at least annual principal payments or deposits to a segregated, interest-bearing account which will result in repayment of the debt at maturity, a systematic reduction of debt means a debt which has:

1. Payments of interest and principal which are uniform over the total length of debt; and
2. A length not exceeding the lesser of forty (40) years or the remaining useful life of the longest lived asset acquired with debt proceeds.

Allowable interest expense is predicated upon required systematic reduction of debt.

If a facility does not make at least annual principal payments or deposits, a systematic reduction of debt will be determined by the Department through:

1. An amortization schedule for a period of thirty (30) years from the date of asset acquisition;
2. Applying the interest rate as stated in the debt contract;
3. For debt contracts entered into prior to July 1, 1990, assuming a principal reduction schedule beginning July 1, 1990, and ending thirty (30) years from the original loan date; and
4. Reducing the calculated interest expense by any investment income on segregated funds.

3.526(d) Interest Expense Related to Refinancing of Debt

The recognizable debt balance following refinancing will be determined as:

Long Term Debt

1. The remaining balance of the original debt as determined under Sections 3.526(b) and 3.526(c); plus
2. The cost of assets acquired in the year of refinancing and then adjusted the following two fiscal years for additional assets acquired; plus

Separate short term Working Capital

1. The financing fees related to the refinancing

The allowable interest expense for refinancing arrangements may not exceed the amount which would have been allowed on the recognizable debt balance, excluding financing fees, had the refinancing not occurred.

Systematic reduction of debt under Section 3.526 is required for refinancing arrangements.

3.526(e) Reduction for Investment Income

The allowable interest expense after applying Sections 1.270 and 3.526(a)1 through 4 will be reduced by the amount of any investment income of the facility or related entities, including foundations, home offices, etc. per Section 1.270, to the extent that total property related expenses exceed the Target (T1) described in Section 3.532. Investment income offset will not include income from donor-restricted funds provided that there is separate accounting for such funds, that the funds are used for their intended purpose, and there is no future benefit to the donor, grantor, or endower. Reserves needed by Continuing Care Retirement Centers to offset lifetime contracts can be calculated by their actuaries if lifetime contracts do not require residents to apply for Medicaid if the resident's fund are exhausted.

3.527 Property Insurance

Allowable property insurance expense will be the accrual-based expense from the base cost reporting period. This expense will be subject to allocations for revenue-producing areas and for non-nursing home areas. Allowable property insurance expense includes mortgage insurance required by the lender.

3.528 Inadequate Documentation

Where the provider, or in the case of changes of ownership, the buyer or seller of a nursing home, is unable or unwilling to provide adequate documentation of acquisition cost, acquisition date or other data relevant to the property-related expenses, or if the provider does not comply with property documentation requests by the Department or the contractor under Section 3.531, the Department will determine the values, dates and data through use of secondary sources of information, such as income and property tax records, and may use the source which results in the lowest value or the lowest property payment allowance.

3.530 Calculation of Property Allowance

3.531 Equalized Value

The equalized value will be derived from the values determined by an independent contractor under contract with the Department, using the E. H. Boeckh Commercial Valuation System. Any values established by such contract will be indexed, if necessary, to the current rate year. The equalized value will be the Depreciated Replacement Cost (DRC) from the E. H. Boeckh valuation after adjustment under Sections 3.531(a) and (b). These values will not be modified by any sales price; by a market appraisal by a certified appraiser on behalf of the facility; or by the assessed value on the property tax rolls.

The total value of the facility will be the sum of the values determined for the separate sections of the facility.

A facility's equalized value shall be based upon the values determined above, including adjustments, unless the facility does not render payment under Section 4.697 within a reasonable time period. In such instance, the facility's property allowance will be reduced by applying 50% of the facility's June 30, 2006, DRC and Undepreciated Replacement Cost (URC) under Section 3.531(b) or by 50% of the facility's June 30, 2006, property allowance, whichever is lower. This reduction applies to both the interim rate granted, if any, and the final rate. Upon facility payment of the appraisal cost, this reduction will be restored on a retroactive basis to the effective date of the reduction, and the facility property allowance will be calculated as determined by the provisions of the Methods.

3.531(a) Allocation for Areas Not Related to Routine Services

The values derived from the Boeckh valuation will be adjusted to exclude the value of areas not related to routine services. To the extent possible, this adjustment will be based on the square footage used in the Boeckh valuation.

3.531(b) Maximum on Equalized Value

The Undepreciated Replacement Cost (URC) arrived at under the Boeckh valuation system shall not exceed the equalized value in Section 5.821 times the beds for rate setting (Section 3.040) for allowances calculated under this Methods. If a facility completed a major phase down under Section 4.560, on or after July 1, 2003, the Undepreciated Replacement Cost (URC) arrived at under the Boeckh valuation system shall not exceed the equalized value in Section 5.822 times the beds for rate setting (Section 3.040) for allowances calculated under this Methods. The effective date for implementing Section 5.822 shall be as stated in Section 4.530. Where this maximum is exceeded, the equalized value will be adjusted proportionately. This calculation can be expressed as follows:

For: Boeckh URC = The Boeckh Undepreciated Replacement Cost after Section 3.531(a) square footage adjustments;

Boeckh DRC = The Boeckh Depreciated Replacement Cost after Section 3.531(a) square footage adjustments

URC = Allowable Undepreciated Replacement Cost (the lesser of Boeckh URC or the equalized value in Section 5.820)

Then allowable Equalized Value (EV) is calculated as:

EV = (Boeckh DRC/Boeckh URC) X URC

3.532 Property Allowance Calculation

A target amount (T1) will be calculated for each facility by multiplying the equalized value from Section 3.531 by a service factor described in Section 5.810 (a).

When a facility's allowable property-related expenses are less than the target amount (T1), the property payment allowance will be allowable expense plus the incentive value in Section 5.840 times the amount by which expense is less than the target (T1). When the facility's allowable property-related expenses are equal to or greater than the target amount, the property payment allowance will be the target amount plus 100% of the amount by which allowable expense exceeds the target up to the factor in Section 5.810 (b), and the cost share value in Section 5.830 times the amount by which allowable expenses under Section 3.521 exceed the factor in Section 5.810 (b).

This calculation can be expressed:

For: E = Allowable property-related expenses up to Section 3.521 maximum;
T1 = The service factor in Section 5.810 (a);
T2 = The service factor in Section 5.810 (b);
PA = Total property payment allowance;

C = Cost Share Value described in Section 5.830; and
N = Incentive described in Section 5.840.

Then: Where E is less than T1:

$$PA = (E + N * (T1 - E))$$

Where E is equal to or greater than T1 and E is less than T2:

$$PA = E$$

Where E is greater than T2:

$$PA = (T2 + C * (E-T2))$$

Nursing facilities that have a licensed bed capacity of 50 beds or less, after adjustments in Section 3.000, will have a cost share as described in Section 5.830(b). Facilities that are certified as ICF/MR, either in whole or in part, will have a cost share as described in Section 5.830(a).

3.534 Per Patient Day Property Payment Allowance

To calculate the per patient day property payment allowance, the property allowance (Section 3.532) is divided by the patient days in Section 1.315. If needed, the expenses shall be adjusted to the length of time covered by the patient days.

For calculating the per patient day property payment allowance for newly-licensed facilities and facilities with significant licensed bed increases, the patient day provisions of Sections 4.320 and 4.420 will apply.

3.537 Maximum Decrease

A facility's payable property allowance will not be reduced by more than $3.50 per patient day from the allowance in effect on June 30, 2006. An exception to this maximum decrease is made if the June 30, 2006, allowance is subject to adjustment after June 30, 2006, for the lapsing of the "start-up" occupancy provisions for newly-licensed or expanded facilities. In these cases, the $3.50 maximum reduction is measured from the allowance which would have resulted from applying the Methods in effect on June 30, 2006.

3.600 PROVIDER INCENTIVES

3.651 Exceptional Medicaid/Medicare Utilization Incentive (EMMUI)

MM% = The facility's Medicaid patient days plus Medicare patient days divided by the facility's total patient days under Section 1.315. The MM% must be greater than or equal to 65.0% in order to receive the EMMUI. The incentive will vary based on the MM% and the beds for rate setting of the facility. A separate incentive is available for facilities located within the city limits of the City of Milwaukee. Payment for the EMMUI supplement will be determined per the table in Section 5.920.

3.652 Energy-Savings Incentive

If a facility completes a remodeling or renovation project specifically designed to reduce consumption of electricity or heating fuels, or to reduce their electricity or heating fuel rates per unit of energy, the facility will receive an incentive equal to the lessor of 25% of the projected cost of the project, as approved by the Department, or 25% of the actual cost of the project per year for two years. The incentive payment will be effective July 1 following completion of the project.

3.653 Private Room Incentive

1. Basic Private Room Incentive (BPRI)
   A basic private room incentive will be determined using the following formula:

   BPRI = PRP x BBA

   where PRP = Private rooms divided by total licensed beds on the last day of the cost report used for the rate calculation. PRP must be greater than or equal to 15% **AND** the facility's Medicaid patient days plus Medicare patient days divided by the facility's total patient days under Section 1.315 must be greater than or equal to 65% in order to receive the BPRI

   and BBA = The basic base allowance in Section 5.930

2. Replacement Private Room Incentive (RPPRI)
   A replacement private room incentive will be determined using the following formula:

   RPPRI = PRP x RBA

   where PRP = Private rooms divided by total licensed beds on the last day of the cost report used for the rate calculation. PRP must be greater than or equal to 90% **AND** the MM% from Section 3.651 must be greater than or equal to 65.0% in order to receive the RPPRI.

   and RBA = The replacement base allowance in Section 5.930

   A facility may receive only one incentive.

3.654 Medicaid Access Incentive

Facilities certified as nursing facilities (NF) will receive the incentive in 5.941. Facilities certified as Intermediate Care Facilities for the Mentally Retarded (ICF/MR) will receive the incentive in 5.942. Distinct part ICF-MR facilities as defined in Section 1.311 will have separate rates reflecting the separate incentives in Sections 5.941 and 5.942.

3.700 FINAL RATE DETERMINATION

3.710 General

Sections 3.710 through 3.770 describe the process for determining a facility's final payment rate by level of care for direct care services, support services and property taxes. This process shall be followed whenever any payment allowance under Sections 3.100, 3.200, or 3.400 is adjusted or recalculated. Any average amount under this section shall be the average as weighted by the patient days by level of care which were used in calculating the direct care allowance under Section 3.100. The Department shall specify the patient day period.

3.720 Base Rate

3.721 Base Rate Described

A facility's base rates shall be the total rates effective for each level of care for services rendered on June 30, 1994, excluding the capital allowance, ancillary add-ons, special allowances for local government-operated facilities and rate adjustments made by the Nursing Home Appeals Board. An average base rate shall be calculated under Section 3.710 for each facility.

3.722 Base Rate Modification

The base rates shall be modified according to the following:

1. Adjustments. Base rates shall include any audit adjustments or corrections subsequent to June 30, 1994, that are deemed effective for date-of-service June 30, 1994.

2. Certification or Licensure Change. Upon a change in certification or licensure level of the facility, the base rate for any added level of care, for which no base rate exists, shall be the base rate from the next lower level of care.

3. Newly-Licensed Beds. A newly-licensed facility which is in its start-up period as of June or July 1994 shall have zero base rates. A facility with significant licensed bed increases which is in its start-up period as of June or July 1994 shall have as its base rates those rates effective at the end of the month prior to the licensure of the new beds.

   Such base rates shall be limited for the current rate calculation to a maximum which shall be the facility's average base expense as determined in Section 3.731. If the average base rate is limited by the maximum, base rates for each level of care shall be calculated by multiplying the unlimited base rates for each level of care by a ratio of the maximum divided by the unlimited average base rate.

4. Temporary Bed Reductions. If the June 30, 1994, base rates were retrospectively adjusted for temporary bed reductions due to renovation projects, such rates shall be the base rates for application of this section until completion of the renovation period. After completion of the renovation period, the base rates shall be those rates effective for date of service June 30, 1994, prior to the retrospective rate adjustment for recognition of the temporary bed reduction.

3.730 Projected Expense

The projected expense shall be the sum of the average expense per patient per day, which was used in the calculation of each allowance in Sections 3.100 through 3.400, after being adjusted to the payment year as follows:

1. Direct care inflation adjusted expense from Section 3.120 shall be inflated by 2.6%.
2. The property tax expense from Section 3.400 shall be inflated by 2.6%.
3. The allowable Support Services expense adjusted to the common period by the composite inflation rate in 5.300 shall be inflated to the reimbursement period by 2.6%.

3.740 Current Methods Rate

A facility's current Methods rate for each level of care shall be the sum of the payment allowances resulting from Sections 3.100 through 3.400. A weighted average current Methods rate shall be calculated.

3.760 Hold-Harmless Rate

The facility's average hold-harmless rates shall be the base rates under Section 3.720.

3.770 Selection of Payment Rate

3.772 Hold-Harmless Rate

The hold-harmless rates under 3.760 shall be the facility's payment rates if both of the following conditions are met:

1. The average current Methods rate under 3.740 is less than the average base rate under 3.720.
2. The average current Methods rate is less than the projected expense under 3.732.

3.773 Current Methods Rate

The current Methods rates under Section 3.740 shall be the facility's payment rates if Section 3.772 does not apply.

3.774 Final

The property allowance determined under Section 3.500 and ancillary add-ons determined under Section 3.800 shall be added to the rates selected under Sections 3.772 or 3.773 above. The sum shall be the payment rates for the facility.

3.775 Special Allowances for Facilities Operated by Local Units of Government

In recognition of the unique nature of nursing homes operated by local units of government, local government-operated homes are eligible to apply for supplemental funding. Government-operated facilities will be consistent with the definitions used in Section 2.710.

A. Supplemental Payments for Local Units of Government

1. In order to participate in the supplement, the home must have on file with the Department and/or submit the following materials:

   a. A cost report as required in Section 1.170.

   b. A prospective supplemental award application form.

   c. An affidavit signed by the executive officer of the local unit of government or by his or her designee, certifying the amount of local government expenditures eligible for FFP under 42 C.F.R., Section 433.51(b), for the purpose of meeting the cost of nursing home care and services.

2. Supplemental funds awarded to the home will be made in lump sum payment(s). Total supplemental funding shall not exceed $37,100,000. The Department shall reduce the supplemental funding to the local units of government if it determines that the aggregate payments to nursing homes under these Methods would exceed the Medicare upper limit calculated in Section 3.780.

3. The following methodology will be used to distribute funds under this Section:

   a. Based upon the cost report and the rates established under the Methods, the Department will determine the following (Medicaid/Family Care-Medicaid) deficits for July 1, 2006 through June 30, 2007: The (Medicaid/Family Care-Medicaid) deficits will be determined by using both the Medicaid and the Family Care-Medicaid patient days.

      1) The Projected Direct Care Operating Deficit (DCOD).

      2) The Projected Overall Operating Deficit (OAOD).

      3) The Eligible Direct Care Deficit (EDCD) (Equal to the lesser of the DCOD or the OAOD).

      4) The projected non-direct care deficit (Equal to the OAOD less the EDCD).

      The Department will issue a report to each applicant facility detailing its DCOD and OAOD.

   b. The Department will distribute, $37,100,000 or the aggregate OAOD, whichever is less, in supplemental funding as follows:

      1) If there are insufficient funds to reimburse facilities EDCD, then the distribution of the remaining funds shall be made as follows:

      The sum of the EDCD shall be divided by the Medicaid patient days for each facility's fiscal year that ended during calendar year 2004, for the facilities with EDCD to determine the average loss per Medicaid patient day.

Each facility shall receive a payment equal to their Medicaid patient days multiplied by the Medicaid EDCD loss per day rate, not to exceed their EDCD.

If there are insufficient funds, the EDCD per day will be reduced so the calculation will equal the remaining funds.

2) If additional funds remain after payment of the EDCD, the sum of the non-direct care deficits shall be divided by the Medicaid patient days to determine a non-direct care loss per Medicaid day. Each facility will receive their non-direct care deficit per Medicaid day, not to exceed their non-direct care deficit.

   If the remaining funds are insufficient to cover all non-direct care deficits, the non-direct care deficit per Medicaid day will be reduced to equal the remaining funds.

3) The awards for each nursing home will be adjusted proportionately based on the Medicaid patient days and the Family Care-Medicaid patient days. The nursing home will receive payments based on the Medicaid patient days.

B. Certified Public Expenditures

The Department will claim Federal Financial Participation (FFP) based on public funds expended for nursing home care for Medicaid residents under 42CFR433.51(b).

1. An interim claim will be made using the certified public expenditure report, with the Medicaid revenue and facility expenses certified by an executive officer of the local unit of government. The state will review the certified expenditure report and adjust the Medicaid revenue as necessary to reflect actual rate payments and any supplements or special payments during the period.
2. The interim claim will be subject to an actual Medicaid cost reconciliation, based on the facilities calendar year cost report. For the July 2006 through December 2006 period, the reconciliation will use one half of the 2006 calendar year expense and the actual Medicaid revenue to compute the public expenditures. One half of the 2007 calendar year expense and the actual Medicaid revenue will be used to compute the public expenditures for the January 2007 through June 2007 period. The direct care expense will be allocated between the Medicaid and non-Medicaid residents using the RUGs 34 case mix indices and the DD CMI. All other allowable cost will be considered equal regardless of the pay source.

The aggregate claim for FFP will not exceed the Medicare upper limit calculated in Section 3.780 for Non-State government-owned NFs and Non State government- owned ICFsMR in Section 3.780.

3.780 Calculation of Medicare Upper Limit

The upper limit is applied in aggregate to each of six categories of nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs/MR):

- NFs owned or operated by the State
- Non-State government-owned NFs
- Privately-owned NFs
- ICFs/MR owned or operated by the State
- Non-State government-owned ICFs/MR
- Privately-owned ICFs/MR

Medicaid payments to any category may not exceed a reasonable estimate of the amount that would be paid for the services furnished by the facilities under Medicare payment principles. This general rule was applied as follows to each category.

- NFs: Medicare pays for skilled nursing facility care under a prospective payment system (SNF PPS) with daily rates published in the Federal Register at the beginning of each Federal fiscal year. These rates vary by facility location, by resident resource utilization group (RUG) classification and cover a specified set of covered Medicare services. The estimated amounts Medicare would pay for Medicaid services within each of the three NF categories are the aggregate payments that would be applicable to Medicaid residents according to their RUG classification under the SNF PPS.

- Since the SNF PPS system does not apply to ICFs/MR and the RUG classification system is not applied to ICF/MR residents, we use aggregate allowable costs for the Medicare Upper Limit for ICFsMR.

  Note also that the calculations of SFY 2007 Medicaid payments and upper limit values are based upon information that is available at the time the State Plan is filed with CMS. That is, the calculations are prospective in nature and actual Medicaid payments may vary from estimates due to differences in actual and expected 2005 cost report data (used to set the Medicaid rates) and SFY 2007 Medicaid patient days, among other items.

3.790 Purchased Relocation Services

Payment for relocation services may be paid as a lump sum, in addition to the daily payment rate, if all of the requirements listed below are met.

- The relocation plan(s) must be ordered by the Department.
- The Department must approve the contractor performing the services.
- Only services such as assessment of the resident for alternate placements, preparing contracts for community-based services and developing the community-based care provided by and paid to an outside contractor are allowable. All staff costs are allowable in the Methods and are not eligible for the lump sum payment.
- The amount allowed must meet all Departmental contracting limits.

The Department will pay the Medicaid portion of the allowed Purchased Relocation Services. The percentage of residents that were Medicaid during the month prior to the relocation order will be used as the Medicaid portion. The Department may, at their sole discretion, pay 100% of the allowed Purchased Relocation Services if the request is made prior to contract signature and it is shown to be in the Departments best interest.

Example: The Nursing Home receives a relocation order from the Department on July 15. They hire Apex Relocation Services to relocate all 100 residents in the next 60 days for a cost of $15,000. The Department approves the contract with Apex and the contract amount of $15,000. During June, 75 of the 100 residents were paid through Medicaid. Therefore, $11,250 ($15,000* 75%) will be paid to The Nursing Home as a lump sum.

If this section does not apply, the relocation services will be included in the cost report and paid accordingly.

3.800 ANCILLARY BILLABLE ITEMS

3.801 Medical Transportation

Medical transportation may be separately billed by a nursing home provider as an ancillary. Billings may not exceed the nursing home's actual cost. A per patient day ancillary add-on to the payment rate may be allowed for the cost of transportation services, but not to exceed the amount which would have been separately billable by the facility. The Department shall retain its authority under s. 49.45(10), Wis. Stats., to modify this paragraph.

3.802 Oxygen

A nursing home may bill for oxygen at a daily rate as described in the Medicaid Update series. The nursing home must use the claim form approved by the Department for oxygen billing. The nursing home will be subject to maximum fees for these services. Prior authorization is required for more than 30 days' rental of an oxygen concentrator for a resident. Ancillaries mentioned in this section cannot be paid as part of the rate but can be billed by the facilities.

3.810 Add-Ons for Separately Billable Items

3.811 Ancillary Add-Ons

A per patient day add-on to the daily rate may be allowed for the cost incurred by the facility for specifically identified covered services and materials which could be billed separately to the Medicaid Program by an independent provider of service. These services and materials must be available to all Medicaid recipients of the facility. If some portion of the services and materials must be supplied by an outside provider, the facility is responsible for payment to the outside provider.

The maximum amount allowed a facility for an add-on shall be the estimated maximum reimbursement available to independent providers for such services and materials when billing the Medicaid Program separately. The Department may exclude all costs in excess of this maximum. Such costs shall be from the reporting period(s) specified by the Department. If an add-on is approved, then neither the facility nor independent provider or providers of service may bill or charge the Medicaid Program separately for the material or services which are covered by the add-on. If a special need arises, i.e., something not covered by the add-on for any resident, the facility must receive approval from the Department in advance, in order for an independent provider to be reimbursed for the service or material.

Ancillaries mentioned in this section cannot be paid as part of the rate but can be billed by the facilities.

NOTE: Each facility with an ancillary must demonstrate that the add-on to the daily rate is equal to or less costly than if the service was reimbursed to an independent provider through separate billings. If a facility requests a new ancillary add-on, the facility must demonstrate to the Department that the add-on meets the requirement of this section before the add-on is approved. The method of reporting the estimated expenditure shall be specified by the Department.

3.812 Adjustment for Changes in Practice

It is possible that a facility may wish to begin or resume billing some services or materials separately, after having had ancillary add-ons previously incorporated into its daily rate. If that occurs, the Department may make a reasonable and appropriate off-setting reduction to the facility's previous or current payment rate to exclude an ancillary add-on for the service. THE FACILITY SHALL NOTIFY THE DEPARTMENT OF THE CHANGE 30 DAYS PRIOR TO THE PROPOSED EFFECTIVE DATE.

3.900 REIMBURSEMENT OF STATE-And TRIBAL-OWNED OR OPERATED FACILITIES

3.910 General

The state and tribal-owned or operated nursing facilities and ICF-MRs serve a unique population of residents in Wisconsin. Determination of payments will be guided by the provisions below and by the appropriate sections of state statute.

3.920 State and Tribal-owned or operated Nursing Facilities

The payment rate for State and Tribal-owned nursing facilities will be the Medicare PPS payment effective during the reimbursement period, based on the Medicaid case mix of the facility.

3.9230 State and Tribal-owned or operated ICF-MRs

The payment rate for state and tribal-owned or operated ICF-MRs will be based on the actual allowable cost during the reimbursement period.

3.9231 Direct Care, Support Services and Property Tax

The maximums and limitations in Sections 3.100 through Section 3.400 shall not be applied in determining payments to state-and tribal operated facilities. The amount of the final payment shall be based upon the actual and allowable costs in the cost reporting period plus the Medicaid Access Incentive in Section 3.654. Interim rates and cost reconciliation procedures are described in Sections 3.960 and 3.980.

3.9232 Capital Costs

Actual and allowable capital expenses for the cost reporting period shall be used to calculate the final property allowance. The property allowance shall be subject to reconciliation under Section 3.980.

3.930 Ancillary Add-Ons

Actual and allowable ancillary expenses as described under Section 3.800 for a time period established by the Department shall be used to calculate the final ancillary add-on costs. Interim add-ons will be set as described in Section 3.960. Underpayments or overpayments for ancillary add-on costs shall be included in the reconciliation described in Section 3.980. The maximums and limitations in Section 3.610 shall not be applied in determining payments to these facilities.

3.950 Reporting Limitations

The facilities shall be subject to all cost reporting requirements. The costs of teaching and vocational counseling services rendered residents under age 22 as part of an active treatment plan are only allowable in facilities licensed as ICF-MRs. The facilities will maintain adequate records so that audits of costs may be conducted to determine payable costs.

3.960 Interim Payment Rates

Interim payment rates may be established and will be subject to the cost reconciliation under Section 3.980.

3.970 Reimbursement Limitation

Total reimbursement for the payment rate year for state-owned facilities for patient care shall not exceed the Medicare upper limit.

3.980 Cost Reconciliation

A cost reconciliation will be conducted at the end of each state and tribal-owned or operated Intermediate Care Facility for the Mentally Retarded (ICF-MR) facility's fiscal year. If payment at the interim rates does not exceed the Medicare upper limit, then the facility will be reimbursed the difference. If the payments at the interim rates are above the Medicare upper limit, then the difference will be recovered. However, in no case shall the total Medicaid payment exceed the limitations described in Section 3.970.

SECTION 4.000 SPECIAL PAYMENT RATE ADJUSTMENTS AND RECALCULATIONS

4.100 RETROACTIVE RATE ADJUSTMENTS

4.110 Retroactivity

The Department has the authority to retroactively adjust the daily rate in such circumstances as audit adjustments, errors in reporting, errors in calculations, implementation of administrative formula provisions, and implementation of rules enacted under s. 49.45(10), Wis. Stats.

4.115 Administrative Reviews and Appeals

Sections 4.110 through 4.150 do not apply to administrative reviews under Section 1.800 or to appeals under Section 1.400 or Section 1.700. The time limits within which administrative reviews or appeals must be filed are determined under the relevant section, rule, and guidelines.

4.120 Material Adjustments

Only audit adjustments and/or corrections of errors which have a combined net material impact on rates and payments for services will be incorporated into the rates. "Material" is defined as the combined net increase or decrease being equal to or greater than an average change of $.050 per patient day. The average change shall be calculated on a weighted average of the change in each level of care payment rate using the patient days from the calculation of the average base rate (See Section 3.710). The materiality test will be applied separately each time payment rates are recalculated for the correction of errors or audit adjustments with the newly-adjusted rates being compared to the rates being corrected or adjusted.

4.130 Within 150 Days

A provider must deliver written notice of errors to the Department within 150 days of the date of the first rate approval letter in order for any corrected rates to take effect on the original effective date of the rates in error. A postmark date shall be considered delivery date. The provider will be limited to only one such retroactive adjustment per rate effective period in order to correct errors in reported data. Departmental corrections to the rate calculation mechanics of the Department shall not be limited to one such retroactive adjustment. Notice or approval of a corrected rate does not initiate a new 150-day period.

If errors are found by the Department, increased corrected rates will be effective on the first of the month following the month in which the error was found and decreased corrected rates will be effective on the original effective date of the rates being corrected. If such errors are found coincident to a notice from the provider of some other errors, then corrections for the findings of the Department shall be incorporated with and allowed to be retroactively effective in conjunction with the corrections resulting from the notice from the provider.

4.140 After 150 Days

If the provider delivers written notice of errors to the Department more than 150 days after the date of the first rate approval letter, corrected increased rates will be effective the first of the month following the month in which the notice was delivered to the Department. Corrected decreased rates from such notice shall be effective on the original effective date of the corrected rates. A postmark date shall be considered delivery date.

If errors are found by the Department, corrected increased rates will be effective the first of the month following the month in which found by the Department. Corrected decreased rates shall be effective on the original effective date of the rates being corrected. If such errors are found coincident to a notice from the provider of some other errors, then corrections for the findings of the Department shall be incorporated with and be effective in conjunction with the corrections resulting from the notice from the provider.

4.150 Audits

Any findings of the Department in the course of an audit shall be considered findings coincident to any written notice of errors delivered by the provider to the Department in the course of the audit. Such corrections submitted by the provider shall be taken into consideration in conjunction with and incorporated with any findings of the Department when determining audit adjusted payment rates. An audit shall be considered completed on the date of the approval letter of the audit adjusted payment rates. This completion date initiates the 150-day period described in Section 4.130.

4.200 CHANGE OF OWNERSHIP

4.210 No Rate Change for New Owner

There shall be no payment rate recalculation due to the change of ownership of a facility or operation which occurs during the payment rate year described in Section 1.130. The new provider will be paid the rate which the former owner was paid or would have been paid if no change of ownership had occurred, unless other provisions of this Section 4.000 allow adjustments to the payment rate. If the change of ownership occurred prior to the payment rate year, July 1 payment rates shall be determined based on a cost reporting period allowed under Section 1.302.

4.220 Prior Owner's Cost Report Required

The cost report for the period during which the facility was operated by the previous owner is still required and must be submitted to the Department unless the Department determines the cost report is not needed. THE NEW OWNER SHOULD ASSURE THE PRIOR OWNER'S COST REPORT IS SUBMITTED. The cost report is presumed to be needed in order for the Department to obtain sufficient data for a full twelve month base cost reporting period allowed under Section 1.302. In those rare instances where it may be impossible to obtain the prior owner's cost report, the Department may determine it is not needed if the cost reporting period for the new owner allowable under Section 1.302 covers a period of at least six months. If the prior owner's cost report is needed, but not submitted, the new provider's rates for the payment rate year specified in Section 1.130 will default to the facility's June 30th rate of the prior payment rate year, exclusive of any amounts for ancillary add-ons and Nursing Home Appeals Board awards and special allowances for local government operated facilities. The Department may reduce those rates by no more than 25.0% if deemed appropriate.

4.230 Property Tax

The property tax allowance shall not be adjusted to recognize a change in tax status upon a change of ownership.

4.300 PAYMENT RATES FOR NEW FACILITIES

4.301 General

Payment rates for a new facility will be established under the rate calculation provisions of Section 3.000. The rate computation will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates. The Department will establish interim rates until rates can be finalized under this section. New facilities are defined in Section 1.305. The Department may deny approval of any rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the new facility. Allowable costs will be deflated and inflated as appropriate with the indices in Section 5.300 and the provisions of the current Methods applied. The property allowance shall be calculated under the provisions of Section 3.500.

The provisions of Sections 4.300 through 4.360 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.310 Start-Up Period

The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the facility was licensed. A facility certified for the Medicaid Program after this twelve-month period shall be considered to have completed its start-up period.

4.320 Payment Rates During the Start-Up Period

Payment rates for the start-up period shall be retrospectively established based on one or more cost reports for the start-up period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the date of certification for Medicaid, and (2) end on, or within the five calendar months after, the end date of the start-up period. The payment rates shall not be effective earlier than the certification date and shall lapse not later than at the end of the start-up period.

The minimum patient days for the property tax allowance (Section 3.400), and the property allowance (Section 3.500) shall be the greater of patient days at 50.0% occupancy of average licensed beds or patient days during the cost reporting period.

4.330 Payment Rates After the Start-Up Period

After completion of the start-up period, rates for a new facility shall be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting periods used under Section 4.320.

4.332 Modified Cost Report Period

The Department may modify the above start-up period and cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.212.

4.333 Base Rates

The base rates for a newly-licensed facility are described in Section 3.722, item 4.

4.335 July 1 Payment Rates

A base cost reporting period shall be designated by the Department for establishing a new facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the start-up period includes the July 1 date, then the July payment rates shall be established under the retrospective provisions for the start-up period. If the cost reporting fiscal year specified in Section 1.302 begins before or during the start-up period, then the Department may designate a more current base cost reporting period for July rates.

4.350 Inflationary Adjustment of Expenses

Cost data from any cost reporting period described above will be inflated or deflated to the common period described in Section 1.303.

4.360 Property Tax Allowance

The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for a new facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the dietary and environmental services allowance in the January 1 payment rate.

4.400 PAYMENT RATES FOR SIGNIFICANT INCREASES IN LICENSED BEDS

4.401 General

The Department may require or a provider may request the payment rate to be reestablished under the provisions of Section 3.000 when a provider significantly increases its unrestricted use licensed beds. The rate computations will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates.

The Department may establish interim rates until rates can be finalized under this section. A significant increase in licensed beds is defined in Section 1.304. The Department may deny approving any adjusted rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the expanded facility. The property allowance shall be recalculated under the provisions of Section 3.500.

The provisions of Sections 4.400 through 4.460 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.410 Start-Up Period

The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the new beds were licensed.

4.420 Payment Rates During the Start-Up Period

Application of this section is optional. Payment rates for the start-up period may be retrospectively established based on one or more cost reports for the start-up period for any or all applicable payment allowances. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the start-up period, and (2) end on, or within the five calendar months after, the end date of the start-up period. The adjusted payment rates shall be effective as of the date of amended licensure.

4.430 Payment Rates After the Start-Up Period

After completion of the start-up period, rates for a significantly expanded provider may be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting period used in Section 4.420.

4.432 Modified Cost Report Period

The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.273.

4.433 Base Rates

The base rates for a significantly expanded facility are described in Section 3.722, item 3.

4.435 July 1 Payment Rates

A base cost reporting period shall be designated by the Department for establishing an expanded facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the start-up period includes the July 1 date, July payment rates may be established under the retrospective provisions for the start-up period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the start-up period, the Department may designate a more current base cost reporting period for July 1 rates.

4.460 Property Tax Allowance

The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for an expanded facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the dietary and environmental services allowance in the January 1 payment rate.

4.500 PAYMENT RATES FOR SIGNIFICANT DECREASES IN LICENSED BEDS

4.501 General

A provider may plan to significantly decrease its number of unrestricted use licensed beds. The Department may require or the provider may request payment rates to be reestablished. If the provider makes the request, the provider must notify the Department in writing prior to the effective date of the reestablished rates and must relinquish the future use of a significant number of licensed beds. Any future use of the relinquished beds must be approved, if required, under Chapter 150, Wis. Stats. The Department may deny rate adjustments under this section if it determines the provider's decrease is not desirable or appropriate.

If the reduction involves an extended and major phase-down, the provider may elect to have rates established under the provisions of Section 4.560 below. If Section 4.560 is not applied, the rate computation will consist of two phases: (1) retrospective rates for the phase-down period, and (2) post phase-down adjusted rates. A significant decrease is defined in Section 1.304. The property allowance shall be recalculated, subject to the targets, maximums and ratios described in Section 3.500.

The provisions of Sections 4.500 through 4.560 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.501(a) Sale of Beds

A rate adjustment will be made under this section only when a provider has surrendered the right to license these beds for reallocation through the Resource Allocation Program (RAP). Thus, where a provider has sold or transferred his right to license beds, without going through the RAP process, the phase-down and facility closing provisions will not be used to adjust Medicaid rates for the facility that is reducing licensed bed capacity.

The costs of acquiring the right to license beds from another provider are non-reimbursable costs.

4.510 Phase-Down Period

The phase-down period is that time period during which the resident population may be reduced and during which licensed beds are being reduced to the objective bed capacity. The provider shall submit a written plan for the phase-down acceptable to the Department. The plan must specify the objective licensed bed capacity, the expected date by which any phase-down of the resident population is to begin, the amount of the phase-down, and the expected date by which the license will be amended to the objective capacity. The Department shall establish the beginning and ending dates of the phase-down period which may be modified as needed during the phase-down.

4.520 Payment Rates During the Phase-Down Period

Application of this section is optional. Payment rates for the phase-down period shall be retrospectively established under Section 3.000 based on one or more cost reports. No retrospective adjustment shall be available if the phase-down period is less than six months. The cost reporting period(s) shall: (1) begin on, or within the five calendar months before or the five calendar months after, the starting date of the phase-down period, and (2) end on, or within the five calendar months after, the effective date of the amended license at the objective capacity. The retrospective payment rates shall not be effective earlier than the beginning date of the cost reporting period and shall lapse at the end of the reporting period.

4.530 Payment Rates After the Phase-Down Period

After a provider's license is amended to the objective licensed bed capacity, payment rates may be reestablished based on at least a six-month cost report acceptable to the Department which will begin after the end of the phase-down period or after the end of the cost reporting period used under Section 4.520. Section 4.530 may be applied to the significantly decreased provider which does not receive a retrospective adjustment under Section 4.520.

4.532 Modified Cost Report Period

The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.273.

4.535 July 1 Payment Rates

A base cost reporting period shall be designated by the Department for establishing the decreased facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the phase-down period includes the July 1 date, then the July payment rates may be established under the retrospective provisions for the phase-down period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the phase-down period, then the Department may designate a more current base cost reporting period for July 1 rates.

4.550 Inflationary Adjustment of Expenses

Cost data from any cost reporting periods described above will be inflated or deflated to the common period described in Section 1.303.

4.560 Major Phase-Down

A major phase-down is: (1) a significant reduction in unrestricted use licensed beds, and (2) a reduction of resident population by 15.0% or more. The determination of the extent of the reduction of resident population shall be based on the average daily resident census, including each bed hold day as one full day, during the cost reporting period which would have been used for establishing payment rates in the first month of the phase-down period if no phase-down rate adjustment had been pursued. Payment rates for such a provider shall be negotiated between the Department and the provider. Rates for some or all related facilities under common control of a parent entity may be affected. The provisions of Section 3.000 need not be applied for determining such rates.

4.580 Facility Closings

A provider may choose to phase out its nursing home operation. In such cases, the provider may request, or the Department may require, an adjustment to payment rates for the period of the phase-out. The Department may deny rate adjustments under this section if it determines the provider's phase-out is not desirable or appropriate. Payment rates for such a provider shall be negotiated between the Department and the provider. The provisions of Section 3.000 need not be applied for determining such rates.

4.600 CHANGE IN FACILITY CERTIFICATION OR LICENSURE

4.601 General

If a provider changes its certification, including certification in whole or in part as an ICF-MR or licensure level, the Department may require, or the facility may request, payment rates to be reestablished under Section 3.000. Only the direct care allowance under Section 3.100 and the final rates under Section 3.700 will be recalculated, based on a cost reporting period for patient days and for direct care wages, purchased services and supply expenses. In lieu of reporting new supply expenses, previously allowed supply expenses may be used in the recalculation if acceptable to the Department. The rate computations will consist of two phases: (1) retrospective rates for the change-over period, and (2) post change-over period adjusted rates. The Department may establish interim rates until rates are finalized. The Department may deny reestablishing payment rates if any required Chapter 150 approval was not received. The Chapter 150 rate maximum, per Section 1.600, shall apply, if applicable, to the facility.

4.605 Rates Not Reestablished

If rates are not reestablished upon a change in certification or licensure level, then the payment rate for any added level of care shall be the rate from the next lower level of care.

4.610 Change-Over Period

The change-over period shall be at least a six-month period but no more than a twelve-month period beginning on the first of the month following the month in which the change was effective.

4.620 Payment Rates During Change-Over Period

Application of this section is optional, and if it is not applied, then Section 4.610 will apply. Payment rates for the change-over period may be retrospectively established based on one or more cost reports for the change-over period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the change-over period, and (2) end on, or within the five calendar months after, the end date of the change-over period. The adjusted payment rates shall be effective as of the effective date of the applicable change.

4.630 Payment Rates After the Change-Over Period

After completion of the change-over period, rates for a changed provider may be reestablished based on at least a six-month cost report for patient days and for direct care wages, purchased services and supply expenses. Such cost reporting period shall begin after the end of the change-over period or after the end of the optional cost reporting period used under Section 4.620.

4.632 Modified Cost Report Period

The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year end, reimbursement period, or other cost reports required in different sections of these Methods to permit more efficient or reliable cost reporting.

4.635 July 1 Payment Rates

A base cost reporting period shall be designated by the Department for establishing a changed facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the change-over period includes the July 1 date, then payment rates for July through the end of the change-over period may be established under the retrospective provisions for change-over period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the change-over period, then the Department may designate a more current base cost reporting period for July 1 rates.

4.650 Inflationary Adjustment of Expenses

Cost data from any cost reporting periods described above will be inflated or deflated to the common period described in Section 1.303.

4.690 Special Care Payments/Non Rate Payments

4.691 Ventilator Dependent and Extensive Care Patients

Ventilator dependent patients who can be transferred from a hospital to a nursing home, may be able to receive a comparable level of service at a lower cost in a nursing home. Upon prior approval of the Department, payment of $475 per day, in lieu of the facility's daily rate, shall be paid for such an individual resident for a period determined by the Department if it has been demonstrated to the satisfaction of the Department that the facility can provide care in accordance with the specific patient's needs. This payment does not apply to patients receiving either Continuous Positive Airway or Bi-level Positive Airway pressure ventilator care. Any such payment or recoupment of same is contingent on care being needed and provided. Payment for related extensive care patients prior authorized for care at the $150 rate before July 1, 1989 will continue to receive this rate, with appropriate continued prior authorization for the payment rate year.

4.692 Facilities for the Treatment of Head Injuries

Facilities providing specialized treatment for head injuries may receive a negotiated rate, in lieu of the facility's daily rate, for each resident participating in the head injury program. Allowable cost principles and formula maximums may be applied to rate calculations. If average head injury occupancy drops below 50.0% for the reimbursement period, allowable costs will be proportionately reduced to reflect costs associated with unoccupied head injury unit beds. Rates may be updated periodically to account for changes in facility costs. The treatment program must be approved by the Department based on established criteria for admission, continuing stay, discharge and other program requirements as determined by the Department. Treatment and rates must be appropriate and receive prior approval of the Department.

Persons interested in a rate for treatment of head injured persons should contact: Administrator, Division of Health Care Financing; P.O. Box 309, Madison WI 53701-0309.

4.694 Residents with AIDS

For requests received prior to October 1, 1993, subject to prior authorization from the Department, a provider accepting a resident diagnosed with AIDS or ARC may receive a payment of $150 per day in lieu of the facility's daily rate. A facility may claim bed hold for the empty bed in a semi-private room occupied by an AIDS patient, even if the facility does not meet the occupancy requirements for bed hold described in Section 1.500.

For requests submitted or renewed on or after October 1, 1993, subject to prior authorization from the Department, a provider accepting a resident diagnosed with AIDS may receive a payment of $150 per day in lieu of the facility's daily room rate. Subject to prior authorization by the Department, an additional payment equal to 85% of the facility's ISN rate may be provided for the empty bed in a semi-private room if the AIDS resident's clinical condition requires isolation and a private room is not available.

4.695 Exceptional Supply Needs

In addition to the rates described in Section 4.691, payment for exceptional supply needs for ventilator dependent patients and patients receiving similar care may be paid, if prior authorization is received by the Department.

4.696 Isolation Rate

Subject to prior authorization from the Department, and except for AIDS residents under Section 4.694, a facility accepting a resident with a communicable disease requiring isolation pursuant to HFS 132.51(2)(b), Wis. Adm. Code, may receive an additional payment of the difference between the nursing home's private pay rate for a semi-private room and the private room rate up to $35 per day in addition to the Level of Care rate.

4.697 Property Appraisals

The nursing facility shall submit payment for property appraisal to the contractor under Section 3.531 upon receipt of appraisal invoice from said contractor after the Department has approved the appraisal. The nursing facility provider shall receive payment authorized by the Department upon verification of appraisal cost payment from the contractor.

4.700 SPECIAL PROPERTY TAX ADJUSTMENT

The property tax allowance per Section 3.400 may be adjusted when licensed bed areas are added or replaced or when service areas are added or replaced through construction, conversion, or renovation. This adjustment is available for both significant and non-significant bed increases. The provider may request this adjustment to the property tax allowance if the expense in the previous tax allowance had been based on an assessment date prior to the month of completion of the construction, conversion, or renovation. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is delivered to the Department. The adjustment shall consider only current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the dietary and environmental services allowance in the January 1 payment rate.

4.800 PAYMENT RATE ADJUSTMENT FOR RENOVATION PERIOD

4.801 General

The payment rates may be retrospectively adjusted when a provider temporarily takes a significant number of licensed bed days out-of-use for the purpose of capital renovation of a portion of the facility. Significant is the lesser of 4500 licensed bed days or 25.0% of the annualized licensed bed days of the facility. The adjusted rates shall be effective only for the period of the renovation but not earlier than the first of the month following the month in which the written request for the renovation rate adjustment is delivered to the Department's Division of Health Care Financing. The period of renovation and the number of beds out-of-use must be acceptable to the Department. The period of renovation must be reasonable and will be subject to approval by the Nursing Home Section Chief or delegate upon recommendation from the provider's Medicaid auditor.

4.810 Calculation

The allowances listed below will be retrospectively adjusted for the reimbursement period. The adjustment will not consider current expenses, only current patient days for the renovation period. The allowances to be adjusted are the maintenance and security components of the dietary and environmental services allowance (Section 3.200), the administrative expense component of the administrative and general services allowance (Section 3.250), the fuel and utility allowance (Section 3.270), the property tax allowance (Section 3.400), and the property allowance (Section 3.500). See Section 3.722, item 4, regarding base rates.

4.850 Payment for Services Provided During Temporary Evacuation

4.851 General

If a facility is evacuated due to a natural or man-made disaster, pursuant to a declaration by the Governor of a state of emergency, the following provisions will apply. The nursing home will be responsible for the services provided during the emergency. The Department shall provide retrospective payment for extraordinary expenses that occurred on or after the first day of the base cost reporting period and associated with the temporary evacuation. Extraordinary expenses include payments for direct expenses or purchased services for temporary accommodations and emergency repairs to the nursing home, including costs associated with the evacuated residents incurred by other service providers in providing care, treatment, housing and housing-related services for the evacuated residents. Payment for extraordinary expenses are not subject to the formula maximums under Sections 3.100 through 3.700.

4.852 Payments

The Department will provide prospective payment during the evacuation period and retrospective payment for extraordinary expenses after the evacuation period.

4.8521 Prospective Payment

The payment rates in effect at the time of the disaster will be paid to the evacuated facility for the care of the relocated residents. The Department may establish an interim payment for extraordinary expenses, subject to reconciliation with a retrospective settlement.

4.8522 Retrospective Payment

The Department shall perform a retrospective cost and revenue settlement subsequent to the evacuation period for extraordinary expenses. Payment for extraordinary expenses is contingent upon the facility pursuing all possible sources of revenue, including third party insurance for resident services, property insurance, business interruption insurance and litigation for damages from responsible parties. Payment may be recouped in part or in full if the facility does not make a good faith effort to pursue all possible sources of revenue for extraordinary expenses or if the facility successfully recovers from these sources.

4.853 Revenues

All revenue received from non-Medicaid sources for extraordinary expenses will be used to reduce reported expenses in cost reports during the period of the emergency. Expenses incurred during the emergency will not be allowable for subsequent prospective rate setting activities.

4.854 Short Term Cost Report

The facility shall submit a short term cost report for the period of the evacuation as determined by the Department. The cost report shall include costs associated with the evacuated residents including costs incurred by other service providers as described in Section 4.851.

4.855 Patient Days for Rate Calculations after the Evacuation Period

Patient days for the time period during the evacuation will be deducted from the cost report period. Patient days will then be annualized to obtain the adjusted patient day ratio.

4.856 Bed hold

For bed hold, the criteria in Section 1.500 apply for the three month period following the evacuation except that for the occupancy criteria, the greater of the average patient day occupancy for the three month period prior to the evacuation or the actual for any of the three months following the evacuation period will be used in the bed hold occupancy test.

4.857 Procedure

1. Normal Rate Setting. A 12 month fiscal year cost report including the evacuation time period shall be submitted by the facility. A separate short term cost report consisting of only the expenses and revenues attributable to the evacuation period shall also be submitted. The short term cost report shall then be subtracted from the 12 month cost report and the remaining costs annualized for normal rate setting purposes.

2. Rate Setting for the Evacuation Period. Expenses from the short term cost report shall have any revenues received as a result of insurance, third party liability, law suits, and related revenue sources for the evacuation offset. The portion of the difference attributable to Medicaid residents in excess of the Medicaid daily payment rates shall then result in additional Medicaid reimbursement.

4.858 Facilities Receiving Evacuees

1. Patient Days. Patient days for evacuees will not be included in patient days used for normal rate setting unless the residents are permanently admitted to the receiving facility. Occupancy determinations used for the rate calculations for the payment system will use the three months period prior to admission of these temporary residents.

2. Base Cost Report Effect. Base cost reports including the evacuation period will be adjusted for all expenses billed to the evacuated facility or facilities and/or associated with the evacuated residents.

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SECTION 5.000 APPENDICES RELATED TO REIMBURSEMENT

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5.100 SUPPLIES AND EQUIPMENT

5.110 General

Dietary Supplies, Incontinence Supplies, Personal Comfort Supplies, Medical Supplies and Equipment, and other similar items reasonably associated with patients' personal living needs in normal and routine nursing home operations are to be provided to Medicaid recipient patients without charge to the patient, the patient's family, or other interested persons. Costs for any such durable and non-durable items are considered to be reimbursed in the facility's daily rate and, therefore, not to be billed or paid for separately.

If a Medicaid recipient specifically requests a brand of a non-durable item:

1. which the nursing home does not routinely supply; AND

2. for which there is no equivalent or close substitute brand routinely supplied to patients by the facility, then the recipient will be expected to pay the actual cost of that item out of personal funds, AFTER being informed in advance that there will be a charge for the item. However, if the non-durable item was ordered by a physician, the recipient cannot be charged. (Reference: HFS 107.09(2)(b), Wis. Adm. Code)

The following is a partial list of items covered by Section 5.000. The Department retains its authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items from the list.

5.120 Dietary Supplies

Artificial sweeteners
Diet supplements (Metrecal, Ensure, Vivonex and related products)
Salt substitutes (Neocurtasal, etc.)
Sugar substitutes

(Note: The cost of dietary supplies is included in the support services allowance.)

5.130 Incontinence Supplies

Catheters (Foley and Condom), catheter sets, component parts, (tubing, urine collection apparatus, e.g., bags, bed bags, etc.)

Diapers - disposable and reusable (including purchased diaper service)

Underpads - disposable and reusable

5.140 Personal Comfort Items and Medical Supplies and Equipment

Alcohols (rubbing antiseptics and swabs)
Analgesic rubs (Ben-Gay, Infrarub, Vicks Vaporub, etc.)
Antiseptics (Betadine, iodine, mercurochrome, merthiolate and similar products)

Baby, comfort and foot powders
Body lotions, skin lubricants and moisturizers (olive oil, Nivea oil and cream, Lubath, Alpha-Keri, Keri Lotion, etc.)
Blood glucose testing supplies, including strips

Cotton tipped applicators and cotton balls

Deodorants
Denture products (adhesives and cleaning products)
Disposable tissues (Kleenex, etc.)

Dressings (adhesive pads, abdominal pads, gauze pads and rolls, eye pads, sanitary pads, stockinette, Opsite and related items)
Enema administration apparatus

Gloves (latex and vinyl)

Hydrogen peroxide

Lemon or glycerin swabs
Lubricating jellies (Vaseline, KY jelly, etc.)

Oral hygiene products (dental floss, toothpaste, toothbrush, Waterpik)

Phosphate enemas
Plastic or adhesive bandages (e.g. Band-aids)

Shampoos (except specialized shampoos as Selsun and similar products)
Soaps (antiseptic and non-antiseptic)
Straws (paper and plastic)
Syringes and needles, Lancets (disposable and reusable)

Tapes, all types
Tincture of benzoin
Tongue depressors
Tracheotomy care sets and suction catheters
Tube feeding sets and components part

NOTE: Although these are the most common of the personal comfort items, this is not intended to be an all-inclusive list. Exceptional supply needs subject to prior authorization are based upon the Department's guidelines pursuant to Section 4.695.

5.150 All Non-Expendable, Reusable Materials

Abdominal binder
Abdominal support
Adaptive dressing equipment
Adaptive eating utensils
Adaptive hygiene equipment
Air cleaner
Air splints
All non-expendable, reusable materials (bedpans, thermometers, Towels, linen, ace bandages, rubber pants, etc.)
Alternating pressure pumps
Apnea monitor
Aquaped (K pad)

Bath bench
Bath lifts
Bath sling
Bed, electric
Bed, hospital
Bed rails
Blood glucose monitor

Commodes
Crib, hospital-type
Crib with enclosed top
Cushions, all types, wheelchairs (See note)

Elbow protectors
Elevated toilet seats
Enuretic alarm
Exercise equipment
Exercycle (exercise bike)

Floor stand, trapeze
Floor stand, weights
Flotation pads
Food pumps
Foot boards (model)
Foot protectors

Geriatric chairs
Gait belts

Hand cones
Hand splints, soft
Hosiery, including support and thrombo-embolytic Disease stockings
Hoyer or other hydraulic or non-hydraulic lift
Humidifier
IPPB (Intermittent positive pressure machine)
IV Poles

Lamp, heat and ultraviolet Lap boards/trays, wheelchair

Mat, exercise
Mattress, air, alternating pressure, gel, foam
Mattress pads
Lower extremity splints/positioners (e.g. mulitodus)

Name tags

Patient lifts
Positioning equipment for wheelchairs, chairs and beds
Prone standers
Pulse oximeter

Reachers
Restraints
Roho, Jay or similar flotation cushion

Safety rails – hallways, bathroom areas (tub, toilet, shower)
Sitz baths – portable
Sliding boards
Standing tables
Suction machine (standard)

TENS units
Transfer devices
Traction apparatus
Trapeze
Tub, rail

Vaporizer, room
Volumetric pump

Walkers, canes, crutches (including quad-canes)
Water mattress
Wheelchairs, all manual
Wheelchairs, power (See Sec 5.160)
Whirlpool
Wrist bands and alarm systems

NOTE: For the purposes of this section, cushions for use in wheelchairs are those available through general medical supply houses and are not those created especially for any particular resident. Positioning equipment for wheelchairs (seating system) is personalized in nature, custom-made specifically for one resident and is used only by that resident. Such equipment may be separately billable as allowed under Section 5.166 below.

5.160 Durable Medical Equipment and Wheelchairs - Exceptions

5.162 General

Durable medical equipment and wheelchairs reasonably associated with a patient's personal living needs in normal and routine nursing home operations are to be provided to Medicaid recipients without charge to the patient, the patient's family, or other interested persons. The cost of all wheelchairs, including geriatric chairs but excluding motorized wheelchairs or vehicles, is included in the nursing home payment rate.

Under certain exceptions, durable medical equipment (DME) and wheelchairs may be billed separately by the supplier if prior authorized. The prior authorization request must document the need for the item according to the exception criteria described below.

5.164 Durable Medical Equipment

Exceptions to permit separate payment for DME may be allowed by the Department if the DME is personalized or custom-made for a recipient resident and is used by the resident on an individual basis for hygienic or other reasons. These items include orthoses, prostheses (including hearing aids), orthopedic or corrective shoes, or pressure relief beds.

5.166 Special Adaptive Positioning or Electric Wheelchairs

The Department may permit separate payment for a special adaptive positioning or electric wheelchair, while a recipient resides in a nursing home, if the wheelchair is prescribed by a physician and the following criteria are met:

1. The wheelchair is personalized in nature or is custom-made for a patient and is used by the resident on an individual basis for hygienic or other reasons, AND

2. The special adaptive positioning wheelchair or electric wheelchair is justified by the diagnosis and prognosis and the occupational or vocational activities of the recipient (i.e., educational, therapeutic involvement).

Exceptions for wheelchairs may be allowed for the recipient who is about to transfer from a nursing home to an alternate and more independent setting.

5.167 References

Information regarding DME and wheelchairs is contained in HFS 107.24, Wis. Adm. Code, and in the DME Provider Handbook. (For more information on prior authorization, see HFS 107.02(3), Wis. Adm. Code.)

5.200 OVER-THE-COUNTER DRUGS

5.210 General

Certain over-the-counter drugs are to be provided to Medicaid recipient patients without charge to the patient, the patient's family, or other interested persons. Costs for any such over-the-counter drugs are considered to be reimbursed in the facility's daily rate and, therefore, not to be billed or paid for separately.

The following is a partial list of items covered by Section 5.200. The Department retains its authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items from the list.

Aspirin
Ibuprofen
Vitamins
Non-covered cough & cold products
Non-covered ophthalmic products
Topical steroids
Antifungals
Vaginal products
Digestive aids
Saliva substitutes
Acetaminophen
Laxatives
Minerals
Antihistamines
Hemorrhoidal products
Antibiotic Ointment
Pediculicides
Decubitus treatments
Capaicin Topical Products
Antidiarrheals

The above list does not represent the entire list of drugs covered under Section 5.200 and other non-covered over-the-counter drugs may be added to this section. Over-the-counter drugs covered under this section must be on the Division of Health Care Financing's approved OTC list or index.

5.300 COST REPORT INFLATION AND DEFLATION FACTORS

Inflation and deflation factors to adjust expenses from nursing home cost reports to the common period are given below. The common period is the twelve-month period prior to the payment rate year. The factors listed below apply to annual nursing home cost reports ending in the following months.

5.310 Direct Care

	January February March 2005	April May June 2005	July August September 2005	October November December 2005
Wages	3.7%	3.2%	2.4%	1.6%
Fringe Benefits	7.3%	5.7%	3.9%	2.4%
Supplies	4.3%	3.6%	2.6%	1.6%
Purchased Services	4.4%	3.6%	2.8%	1.9%

5.320 Support Service

	January February March 2005	April May June 2005	July August September 2005	October November December 2005
Composite Support Service Expenses	5.6%	4.7%	3.6%	2.2%

5.350 Over-the-Counter Drugs

Inflation rate to the common period	4.3%	3.6%	2.6%	1.6%

5.360 Alternate Cost Report Periods

The Department may establish alternate inflation or deflation factors for cost reporting periods not listed above.

5.400 DIRECT CARE PAYMENT PARAMETERS

5.410 Labor Factors

County	Labor Factor	County	Labor Factor
Adams	0.957	Ozaukee	1.078
Ashland	0.957	Pepin	0.957
Barron	0.957	Pierce	1.131
Bayfield	0.957	Polk	0.957
Brown	0.967	Portage	0.957
Buffalo	0.957	Price	0.957
Burnett	0.957	Racine	0.988
Calumet	0.974	Richland	0.957
Chippewa	0.961	Rock	0.977
Clark	0.957	Rusk	0.957
Columbia	1.082	St. Croix	1.131
Crawford	0.957	Sauk	1.082
Dane	1.082	Sawyer	0.957
Dodge	0.957	Shawano	0.957
Door	0.957	Sheboygan	1.034
Douglas	1.038	Taylor	0.957
Dunn	0.957	Trempealeau	0.957
Eau Claire	0.961	Vernon	0.957
Florence	0.957	Vilas	0.957
Fond du Lac	0.912	Walworth	0.957
Forest	0.957	Washburn	0.957
Grant	0.957	Washington	1.078
Green	0.957	Waukesha	1.078
Green Lake	0.957	Waupaca	0.957
Iowa	1.082	Waushara	0.957
Iron	0.957	Winnebago	1.021
Jackson	0.957	Wood	0.957
Jefferson	0.957	Menominee	0.957
Juneau	0.957		
Kenosha	1.010		
Kewaunee	0.967		
La Crosse	1.012		
Lafayette	0.957		
Langlade	0.957		
Lincoln	0.957		
Manitowoc	0.957		
Marathon	1.021		
Marinette	0.957		
Marquette	0.957		
Milwaukee	1.078		
Monroe	0.957		
Oconto	0.967		
Oneida	0.957		
Outagamie	0.974		

5.420 Case Mix Weights

Level of Care	Case Mix Weight
DD3	1.07
DD2	1.51
DD1B	1.84
DD1A	1.84
ICF4	0.24
ICF3	0.24
ICF2	0.49
ICF1	0.68
SNF	0.97
ISN	1.26
Ventilator	3.89

RUGs Group	Case Mix Weight
SE3	2.10
SE2	1.79
SE1	1.54
RAA	1.07
RAB	1.24
RAC	1.31
RAD	1.66
SSA	1.28
SSB	1.33
SSC	1.44
CA1	0.95
CA2	1.06
CB1	1.07
CB2	1.15
CC1	1.25
CC2	1.42
IA1	0.67
IA2	0.72
IB1	0.85
IB2	0.88
BA1	0.60
BA2	0.71
BB1	0.82
BB2	0.86
PA1	0.59
PA2	0.62
PB1	0.63
PB2	0.65
PC1	0.81
PC2	0.83
PD1	0.89
PD2	0.91
PE1	0.97
PE2	1.00
RUGs Bedhold	0.59

5.421 Source of the RUGs Case Mix Weights from Various Reporting Periods

Reporting Period	Picture Date	Data Available as of Date:
Jan 2004 – Mar 2004	Mar 31, 2004	July 31, 2006
Apr 2004 – Jun 2004	Jun 30, 2004	July 31, 2006
Jul 2004 – Sep 2004	Sep 30, 2004	July 31, 2006
Oct 2004 – Dec. 2004	Dec. 31, 2004	July 31, 2006
Jan 2005 – Mar 2005	Mar 31, 2005	July 31, 2006
Apr 2005 – Jun 2005	Jun 30, 2005	July 31, 2006
Jul. 2005 – Sep 2005	Sep 30, 2005	July 31, 2006
Oct. 2005 – Dec. 2005	Dec 31, 2005	July 31, 2006

5.422 Source of the Reimbursement Period Case Mix Index

Picture Date	Data Available as of Date:	Rate Effective Date
Dec 31, 2005	Jul 31, 2006	July 1, 2006
Jun 30, 2006	Nov 30, 2006	Jan 1, 2007

5.430 Direct Care Base

The Primary Nursing Services Base is $60.36
The Primary Other Direct Care Supplies and Services Base is $10.10

The Alternate Nursing services Base is $58.91
The Alternate Other Direct Care Supplies and Services Base is $9.82

5.440 Direct Care Cost Inflation Increment

The Nursing Services inflation increment is $1.92
The Other Direct Care Supplies and Services inflation increment is $0.32

5.450 Statewide Employee Meal Allowance

The statewide employee meal allowance is $4.25

5.460 Behavior/Cogitative Impairment Supplement

The Base for the Behavior/Cogitative Impairment Supplement is $0.11

5.500 SUPPORT SERVICES PAYMENT PARAMETERS

5.510 Support Services Target and Increment

Target T = $40.39 for common period.
Increment = $ 1.28 to adjust costs to payment rate year.

5.700 PROPERTY TAX PAYMENT PARAMETERS

5.710 Real Estate Tax and Municipal Fees Inflation Rates.

1. Inflation for real estate taxes = 7.0%
2. Inflation for municipal fees = 7.0%

5.800 PROPERTY PAYMENT PARAMETERS

5.810 Service Factors

1. T1 6% of equalized value (after adjustments under Sections 3.531(a) and (b)
2. T2 7.5% of equalized value (after adjustments under Sections 3.531(a) and (b)

5.820 Equalized Value

5.821 Equalized Value: $58,900

5.822 Major Phasedown approved by the Department under Section 4.560 on or after July 1, 2003 $75,900

5.830 Cost Share Value

a. Cost Share Value: 20%

b. Cost Share Value for nursing facilities with 50 or fewer beds for rate setting referenced in Sections 3.040, including any distinct part ICF-=MR or distinct part IMD units in the total facility. 40%

5.840 Incentive Value
Incentive Value: 20%

5.900 OTHER PAYMENT PARAMETERS

5.920 Exceptional Medicaid/Medicare Utilization Incentive

Min MM%	Max MM%	Incentive >50 Beds	Incentive <=50 Beds	Incentive City of Milw.
95.00%	100.00%	2.70	4.20	4.60
90.00%	94.99%	2.45	3.65	4.00
85.00%	89.99%	2.20	3.10	3.40
80.00%	84.99%	1.90	2.50	2.75
75.00%	79.99%	1.70	2.00	2.20
70.00%	74.99%	1.50	1.50	1.65
65.00%	69.99%	1.30	1.30	1.45

Beds referred to in this table are beds for rate setting.

5.930 Private Room Incentive
Base allowance for the private room incentive = $1.00
Replacement allowance for the private room incentive = $2.00

5.940 Medicaid Access Incentive

5.941 Nursing Facilities = $3.69

5.942 ICF/MR Facilities = $16.21

5.950 Specialized Psychiatric Rehabilitation Services
Specialized Psychiatric Rehabilitation Services $9.00 per qualifying resident per day

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SECTION 6.000 MEDICAID NURSING HOME PAYMENT RATE METHODS ADDENDUM FOR STATE PLAN PURPOSES

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6.100 COST FINDING AND REPORTING

6.110 Provider Cost Reports

All NF and ICF-MR facilities, which are certified to participate in the Medicaid program, must complete the uniform cost report prescribed by the Department. Completed cost reports must be submitted to the Department normally no later than three months after the close of each cost reporting period. An additional 30 days may be allowed to facilities that have a certified audit completed for the period of the cost report. A copy of the audit report including certified financial statements and notes thereto must be submitted with the cost report. The cost of central administrative services generally are to be reported using the Department's home office cost allocation report, a Medicare cost allocation report, or another cost allocation report acceptable to the Department.

The cost reports, which will be based on the uniform chart of accounts approved by the Department, must be completed in accordance with generally accepted accounting principles (GAAP) and the accrual method of accounting. The Department may allow exceptions to reporting under certain specific accounting standards. Facilities under 30 beds may be exempted from accruing certain items. Governmental institutions normally operated on a cash method of accounting may use this method, if they so desire.

Also see Section 1.170 of this Methods regarding cost reporting requirements.

6.120 Cost-Finding Method

The cost-finding method used by NF and ICF-MR facilities is described in the cost report. The cost report requires basic cost and statistical information used in the calculations of the payment rates.

6.130 Actual Costs Considered

The Methods referenced in this Methods are intended to take into account the reasonable, actual costs of nursing home services and to provide rates which will be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated. This level is determined from study and analysis of cost reports submitted by facilities. Such an analysis may include the use of representative sample of facilities' cost reports.

6.200 AUDITS

6.210 General

The Department will periodically audit cost reports submitted by nursing home providers and the related financial and statistical records of the providers. The providers selected for on-site audit and the scope of the on-site audit will be determined by: (1) a desk analysis of the cost report submitted by each provider or (2) other criteria determined by the Department. On-site audits will generally be selective in scope.

6.220 Desk Analysis of Cost Reports

Upon submission of the cost reports to the Department, desk reviews will be conducted by Department auditors to determine that, to the extent possible and necessary for rate-setting: (1) only those expense items that the Department has specified as allowable costs are included in the computation of the costs of the nursing home services and (2) expenses have been reliably reported.

Based on the results of the cost report analysis, some of the submitted cost reports will be selected for further on-site examination. The audit will be limited to specific items in the cost report based on the desk analysis or other observations.

6.230 Overpayments Identified and Recovered

Overpayments identified in the audit of a nursing home provider's cost report(s) will be recovered from the provider. Immaterial amounts may not be recovered.

6.300 SEPARATELY BILLABLE ANCILLARY ITEMS

6.310 Items

The costs for the following items may be billed separately by the nursing home and, thus, are not included in the calculation of the daily payment rate of the nursing home:

1. Tracheostomy and ventilatory supplies and related equipment, subject to guidelines and limitations published by the Department.

2. Transportation provided by a nursing home to permit a recipient to obtain health treatment or care if the treatment or care is prescribed by a physician as medically necessary and is performed at a physician's office, clinic, or other recognized medical treatment center. Such transportation may be provided in the nursing home's own controlled equipment and by its staff, or by common carrier, such as bus or taxi.

3. Oxygen, or the daily rental of oxygen concentrators. (The nursing home will be subject to maximum fees for these services, and prior authorization is required for more than 30 days rental of an oxygen concentrator.)

6.320 Reimbursement Manner

The costs of services and materials identified above which are provided to patient recipients shall be reimbursed in the following manner:

1. Claims shall be submitted under the nursing home's provider number, and shall appear on the same claim form used for claiming reimbursement at the daily nursing home rate.

2. The items shall either have been prescribed in writing by the attending physician or the physician's entry in the medical records or nursing charts shall make the need for the items obvious.

3. The amounts billed shall reflect the fact that the nursing home has taken advantage of the benefits associated with quantity purchasing.

4. Reimbursement for questionable materials and services shall be decided by the Department.

5. Claims for transportation shall show the name and address of any treatment center to which the patient recipient was transported and the total number of miles to and from the treatment center.

6. The amount charged for transportation may not include the cost the facility's staff time, and shall be for an actual mileage amount.

6.400 REIMBURSEMENT OF OUT-OF-STATE NURSING HOMES

Nursing home services may be provided to a Wisconsin Medicaid recipient in a nursing home located outside the State of Wisconsin, provided the home is certified in the Medicaid program of the other state.

Payment for temporary coverage of the Wisconsin recipient at the out-of-state home will be at a standardized payment rate for the month of admission and for a maximum of three full calendar months after the admission date. The Department will establish the standardized payment rate based on the approximate average payment rate for a comparable level of care as paid to Wisconsin nursing homes in the July preceding the admission date.

A payment rate more specific to the out-of-state nursing home may be established if: (1) the temporary coverage payment rate is not appropriate for the patient; (2) the temporary rate is not appropriate for the nursing home; (3) the facility requests a specific payment rate; or (4) the period of the temporary payment rate has been completed.

In determining a different rate, the Department may take into consideration: Medicaid rates which are being paid to the facility by states other than Wisconsin; payment for similar services in Wisconsin; available information on the cost of the facility's operation; and any specialized services or unique treatment regimens which may not be available in Wisconsin at a similar or lesser cost.

Ancillary items listed in Section 3.800 may be separately reimbursed to the out-of-state nursing home, if coverage for such materials or services is not included in the daily care rate.

MEDICAID NURSING HOME PAYMENT RATE METHODS

ADDENDUM: COSTS FOR OBRA '87 COMPLIANCE

6.500 REIMBURSEMENT OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA '87) REQUIREMENTS

6.503 Payments for OBRA '87 Requirements

Upon compliance, the allowance under Section 3.100 has been adjusted for facilities over 120 beds for the addition of qualified social workers. Notwithstanding Section 3.121, the facility's actual allowable direct care expenses shall be inflated from the cost reporting period to the common period, to fund costs incurred to comply with OBRA '87, as well as the annual estimated inflationary increase.

In Section 3.251 describing the calculation for Administrative and General Services allowances, the expense factor is defined as the facility's allowable expenses (per patient day) adjusted by a composite inflation factor, including annual inflation and cost inflation to comply with OBRA '87 applied to the common period.

6.503(a) For ICF facilities converting to NF facilities

The related direct care costs have been included in the allowable costs reported under Section 4.600.

6.506 Compliance with OBRA '87 Requirements

The Department's Bureau of Quality Assurance determines compliance with OBRA '87 for each nursing facility. Allowances under Section 6.503 of these Methods will only recognize costs determined by Bureau of Quality Assurance to be related to OBRA '87 compliance.

6.507 Professional Nurse Staffing Requirement

Nursing homes' rates have been adjusted for the incremental costs to meet OBRA requirements relating to having a professional nurse (RN or LPN) on duty at all times. One of the following conditions had to be met to be eligible for the adjustment:

1. The facility has 50 or fewer licensed beds, or

2. The facility changed its certification from intermediate care facility (ICF) to nursing facility (NF) on or after October 1, 1990.

The adjustment may be effective on the first day of the month following the date the facility fulfilled the staffing requirement. The adjustment may allow payments for direct care services to exceed the maximums which are applied under Section 3.100, by 20%. The costs have now been incorporated in the base cost reports for qualifying nursing homes, and the adjustment has been addressed through incorporating the provisions in the Methods in Section 3.122.

COMPARISON OF OBRA '87 AND OBRA '90 WITH WISCONSIN NURSING HOME REQUIREMENTS
(CH. HFS WIS. ADMIN. CODE)

1. Nurse Staffing

State regulations under HFS 132.62(2) and (3), Wis. Adm. Code, comply with OBRA '87 requirements in all areas.

2. Other Staffing

Requirements in this area with the exception of social worker staffing, are met by State regulations under HFS 132.63 (dietary services), 64 (rehabilitative services), .65 (pharmaceutical services), .66 (laboratory, radiologic and blood services), .67 (dental services), and .69 (activities), Wis. Adm. Code. Medical records requirements are fulfilled under HFS 132.45, Wis. Adm. Code. Currently, Wisconsin requires either a full-time or part-time social worker (HFS 132.68(2), Wis. Adm. Code), while OBRA mandates at least a full-time social worker for facilities over 120 beds.

3. Continuing Education for Nurse Aides

HFS 129, Wis. Adm. Code, effective July 1, 1991, complies with all OBRA requirements.

4. Resident Assessment

Current State requirements at HFS 132.52(3) through (6), Wis. Adm. Code, require evaluation and assessment at the time of admission to the facility. A minimum data set and resident assessment protocols are required along with a quarterly review and annual reassessment. The State has specified the HCFA MDS as the resident assessment instrument for all nursing homes in the State to use.

5. Plans of Care

The initial Plan of Care (HFS 132.52(4), Wis. Adm. Code) is required under state code upon admission to a facility and, within 4 weeks of admission, a care plan must be written. The care plan must be reviewed, evaluated, and updated as necessary (HFS 132.60(8), Wis. Adm. Code). Required areas/contents of the care plan correspond to OBRA '87 requirements. While timing of the comprehensive plan differs from OBRA '87, other requirements, in general, comply.

6. Resident Personal Funds

State regulation under HFS 132.31, Wis. Adm. Code, requires all resident funds be deposited in an interest-bearing account with separate accounting for each resident. A quarterly report must be made to each resident except in cases of discretionary expenditure authority for the facility, in which case, reporting may be monthly. To comply with OBRA '87, facilities will have to establish a second, non-interest bearing account or petty cash fund for amounts under $50 and re-adjust for current interest-bearing monies under $50. Further, facilities must notify resident when his/her account reaches $200 less than the MA eligibility limits. Monitoring compliance with these requirements performed by the state survey agency and the state Medicaid agency is based on an interagency agreement.

7. Resident Rights

All State requirements for facilities meet the OBRA requirements regarding all residents rights issues. However, the State continues to work with facilities to reduce both physical and chemical restraint use in nursing facilities.

8. Compliance with the Definition of a Nursing Facility

All facilities are in compliance with the OBRA definition of a nursing facility or operating under a waiver of specific portions of the regulations.

SUMMARY OF OBRA NURSING HOME COMPLIANCE

1. Nurse Staffing

   - No additional cost.

2. Plans for Care

   - No additional cost.

3. Resident Assessments

   - No additional cost will be incurred in this rate period.

4. Other Staffing Requirements (Social Workers)

   - No additional cost.

5. Continuing Educations (Nurses Aides)

   - No additional cost.

6. Resident Rights (freedom from restraints)

   - No additional cost will be incurred in this rate period.

7. Personal Funds

   - No additional cost.

8a. Physical Plant Projects (HVAC and ancillary space)

   - No additional costs will be incurred during this rate period.

8b. ICF Conversions

   - No additional cost in this rate period.

9. Services Required to Ensure the Highest Physical, Mental and Psychosocial Well-Being of Each Resident

   - No additional cost.

FY 00 ESTIMATED COST = $ -0- OR $ -0- PPD

ANALYSIS AND SUMMARY FOR OBRA '87 AND '90

Wisconsin has reviewed its estimates for the cost of implementing the requirements of OBRA '87 and OBRA '90. The following represents the cost analysis and summary of OBRA implementation for the payment rate year.

Several sources were used to estimate costs of OBRA '87. Primarily these are the survey guidelines issued by HCFA reviewed against costs itemized on nursing facility cost reports, two clinical resident surveys conducted in a group of Wisconsin's nursing facilities, and an analysis of facility staffing collected during annual facility surveys. For both the resident assessment system and freedom from restraint requirement, resident sampling was conducted to estimate additional staff time needed to conduct the activities necessary to comply with the new requirements. This information is updated with survey information as it becomes available and cost report information that document staffing in NFs and ICF-MRs. We believe that facilities completed implementation of OBRA on or before October 1, 1990, as required by federal law. The cost reports for rate setting are from facility fiscal years subsequent to 1990; therefore, the cost of implementing the requirements of OBRA '87 and OBRA '90 are now totally incorporated into the cost reports that are used for the payment plan.

1. Nurse Staffing: For the facilities licensed and certified as SNF (NF) prior to implementation of OBRA '87, it is determined that no additional costs are being incurred since current state regulations already comply with OBRA '87 requirements in this area. (See Comparison on Current Wisconsin and OBRA '87 Requirements.)

2. Plans of Care: It is anticipated that no additional costs are being incurred to comply with the Plan of Care Requirements. (See Comparison of Current Wisconsin and OBRA '87 Requirements.)

3. Resident Assessments: The agency, in a joint effort with the nursing home industry, conducted a sample survey of residents in ten nursing facilities to determine the additional time necessary to fulfill the requirements to complete the new MDS and RAP. An average of 2.63 additional nursing hours were needed, an average 1.13 social work hours and an average 0.74 activity hours were reported. Based on the average salary and fringe benefit costs from 1988 cost reports, inflated to the 1990-91 year, the estimated implementation cost was $2.0 million. It is assumed that the total cost of implementation has been reported on facility cost reports that will be used for establishing rates.

4. Other Staffing: Survey results indicate no additional needs beyond the funding made available during the 1990-91 rate year.

5. Continuing Education for Nurses Aides: Based on revised regulations, continuing education requirements for nurses aides have been significantly reduced over original OBRA estimates. No additional funding is required.

6. Resident Rights: Implementation of this requirement was completed during previous cost report periods.

7. Resident Personal Funds: Implementation of these requirements indicate no additional funding will be necessary for the payment rate year.

8. Compliance with the Definition of "Nursing Facility":

   a. Physical Plant Requirements. Review of the new Federal Survey Guidelines indicated that major renovations may be necessary for a number of facilities to bring their heating, ventilation and air conditioning (HVAC) systems up to compliance with OBRA '87 temperature requirements. To estimate costs, 18 previous projects were identified and the average cost of these projects was used as the cost of new projects. In addition, it is anticipated that some facilities will have to construct additional spaces for activities, therapies and other ancillary services. The cost basis for these construction projects to "ancillary areas" is estimated at the equivalent of 50% of the construction of new bed areas.

      Total necessary HVAC renovation and ancillary space additions are expected to cost $3.2 million in prior rate years. We believe that all facilities are now in compliance with the definition of a nursing facility and costs have been incorporated into the cost reports.

   b. ICF Conversion. The basis for this estimate is the change in rates for 11 facilities converting from ICF to SNF licensure since July 1, 1987, inflated forward. The average change was applied to patient days for the remaining 14 ICF facilities at an estimated cost of $1.092 million. All conversions have been completed prior to this rate period; therefore, their conversion costs are included in the cost reports that will be used to establish rates for this reimbursement period.

9. Services Required to Ensure the Highest Physical, Mental and Psychosocial Well-Being of Each Resident: The costs of this requirement are included in the resident direct care costs estimated in items 1-6. The objective of requirements included in these items is the maximization of physical, mental and psychosocial well-being of all residents.